COLLABORATIVE PUBLIC HEALTH AND CHRISTIAN HEALING: A CRITICAL CONVERSATION

by

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ABSTRACT

Introduction – Preventative public health and Christianity as action guiding worldviews share a compassionate, caring and communitarianism approach to health and wellbeing. Although they may say different things about what it is to be fully human, there are many times when their core values and interests are shared and aligned.

Question – What are the opportunities and obstacles for collaboration between action guiding worldviews of Christianity and preventative public health in the United Kingdom?

Method – In order to identify and the opportunities and obstacles of collaborative healing, the ideologies and interaction of two case studies (depression and HIV/AIDs) with wider societal philosophies were examined. The study was conducted through a practical theology approach of theological reflection and conducted via a critical conversation methodology.

Results – The ability to work utilising a whole systems, community and interdisciplinary approach were some of the major opportunities, while the current hiatus in dialogue, equivocal effect on stigma (reduce and increase) and deficiency of religious or health literacy were the major obstacles for collaboration.

Conclusion – Collaborative healing between public health and Christianity within the UK can be coordinated through a community model. In order to improve health and wellbeing in current UK postmodern society, it is key to foster mutual dialogue across interdisciplinary action guiding worldviews.

DEDICATIONS

I begin in the name of God, the Most Merciful and Most Kind. All Thanks and Praise is due to God, Lord, Cherisher and Bestower of mercy to the entire universe. Infinite salutations and blessings on the beloved of God; Prophet Muhammad (Peace and blessings be Upon Him) his family, his companions and the righteous of his community.

Personal

This study is dedicated to my parents, whose love and affection has provided me with the foundation for all my achievements. This exertion is also dedicated to my wife Mudassar Fatima and children; Usman, Zaynab and Hassan all of whom sacrificed their most precious possession and allowed me the time to commence and complete this study.

Professional

It is hoped that this study can provide a beacon of light for all those who have an interest and would like to pursue the difficult and complex terrain of interdisciplinary research that intertwines public health and their faith.

“Where the needs of the world and your talents cross, there lies your vocation” (Aristotle).

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I begin in the name of God, the Most merciful and Most Kind. All thanks and praise are due to God, Lord, Cherisher and Bestower of mercy to the entire universe. Infinite salutations and blessings on the beloved of God; Prophet Muhammad (Peace and blessings be upon him) his family, his companions and the righteous of his community.

I am indebted to numerous of people who assisted me through their support during this study. In particular, I would like to start by thanking my academic supervisors; Dr Andrew Davies with whom I had the initial discussion regarding this study in 2016 and who by the workings of fate facilitated me in its final stages, Dr June Jones, who throughout the three years was the voice of reason for me that kept me focussed on the task at hand and Professor Stephen Pattison, an individual who has had an immense impact on my theological understanding of health and life. Without the support of Dr Adrian Philips and Safina Mistry, I would not have been able to commence this study in its formative stages, whilst at Birmingham City Council Public Health.

Finally, I would like to thank my family for their constant support in times of trepidation and triumph during my journey of this study. I conclude by the Blessed words of Prophet Muhammad (Peace be upon him) “Take advantage of five before five: your youth before your old age, your health before your illness, your riches before your poverty, your free time before your work, and your life before your death.” (Al-Hakim)

Praise be to God, Lord of all the worlds.

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INTRODUCTION

Outline of Chapter

This introductory chapter will commence by outlining the concepts of life and health worlds. It will then examine the concepts of action guiding worldviews and how they influence human action. The next sections will analyse the numeration of religious affiliation within England & Wales and how religion has influenced the development of health care within the UK. The final section will outline the structure of the thesis.

What are life and health worlds?

Health, illness and healing are multidimensional constructs of reality, constituted within the frame of a person's objective, social and subjective worlds, i.e. their lifeworld. The lifeworld of individuals can be viewed, "as represented by a culturally transmitted and linguistically organised stock of interpretive patterns" that provides a horizon for action (Habermas, 1987:124).The theory of communicative action and effective dialogue approach of Habermas can provide insight into the health seeking behaviours of individuals and communities through understanding their complex rationality and values via a critical conversation (Walseth and Schei, 2011). An individual's religion or action guiding worldviews are very much a component of their life and health worlds, providing a sense of coherence to behaviours, norms and values. Although lifeworlds often sustain unwavering authority over individuals and communities, they are malleable as components of these lifeworld realign in and out of consciousness dependent on distinct action situations (Gunderson & Cochrane, 2012: 91-93). The healthworld of an individual is an embedded region of the lifeworld and refers to the conceptualisation and ontological construction of health and wellbeing that drive health seeking attitudes, agency and action (Germond and

Cochrane, 2010). The healthworld symbolises the telos of life as it attempts to achieve wholeness, which for many can be provided through religious ideologies due to their conceptual inseparability of religion and health (Gunderson & Cochrane, 2012: 94). As healthworlds describe patterns of health seeking actions determined predominantly by anthropological constructions (within lifeworld), they are able to explicate the complexity of health seeking methodologies, as well as providing perspectives on how health outcomes may be enhanced through elucidation of healing opportunities (Germond and Cochrane, 2010).

In many communities a diverse array of life and health worlds co-exist, resulting in a complex spectrum of narratives, motivations and iconography regarding health and illness and therefore the existence of pluralistic or mixed healing strategies. However, the dominant contemporary conception of health and healing in the United Kingdom (UK), both within individuals and the National Health Service (NHS) has been subjugated by the positivist essentialist medical model (Pattison, 1989:22).

The World Health Organisation (WHO), however, defines health in broader holistic terms, espousing a biopsychosocial model:

‘Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.’ (WHO, 1948)

This definition has remained unchanged since 1948 and considers health and wellbeing in terms of physical, mental and social states. The philosophical underpinnings of this delineation link health and wellbeing to the connectedness of mind, body and spirit (Davie, 2015:212). Challenging the hegemony of the medical model to health, illness and healing, Engel (1977), characterises the medical model as reductionist and embracing a Cartesian mind-body dualism, with a focus on

physicalist disease aetiology. Engel advocated a transition from this parochial model to a biopsychosocial model that resonated with the WHO definition, viewing health and healing as a corollary of complex interacting mechanisms at the cellular, interpersonal and environmental level. Although the medical model and high-tech medicine have been highly successful in the relief and elimination of illness, the mind and body, as well as body and soul dualisms has depersonalised the patient with its individualistic curative perceptions and inadequate consideration of the whole patient (holism) interacting with the wider social determinants of health (Pattison, 1989:24). In spite of regular criticism, the biopsychosocial model has influenced fundamental components of medical research and practice and could be used more optimally through incorporation of learning from interdisciplinary research and healthcare management (Farre and Rapley, 2017).

Healthworlds, in summary are the complex reality of health beliefs, behaviours and perceptions influenced by existing lifeworlds determined by societal, religious, biomedical or cultural norms and values. The amalgam of healthworlds; religious or biomedical within individuals and communities are dynamic and a better understanding of these action guiding integrated pluralistic health seeking strategies will allow the improvement of current health delivery systems (Gunderson & Cochrane, 2012: 97-98).

Action guiding worldviews

All human action emerges within the context of secular or religious action guiding beliefs and worldviews. A worldview is a set of presuppositions that provide a coherent and unified framework for understanding ontological, axiological, praxeological and epistemological explanations of reality (Irzik and Nola, 2009; Vidal, 2008). A worldview enables the unification of thought and life, provides hope,

meaning and can guide action (Holmes, 1983:5). Practical human action and decisions concerning life take place within the context of action guiding theistic or non-theistic worldviews and belief systems (Browning, 1991:6). The worldviews of religion and medicine (health) are often thought to be irreconcilable (conflicting); however, the relationship between these worldviews has also been described as non-antagonistic incommensurable and complementary (Harrison, 2006) due to the common dynamics they share in function of human life (Vanderpool and Levin, 1990). The construal of a complementarity relationship offers the opportunity for ongoing creative dialogue between these worldviews that can facilitate transformative exploration to tackle contemporary challenges. Contrary to the common supposition that modern medicine is areligious and exclusively secular, (Vanderpool, 2008) explicates many phenomenological features of religion (salvation, rituals and dogmatic) discernible in medical philosophy and practice.

As an action guiding ideology, Christianity within the UK has contributed extensively to the maturity of many therapeutic and preventative public health care institutions through its religious ideas, motives and practices. Just the nomenclature of many leading and current modern hospitals within the NHS bears reference to their religious origins; St Thomas (12th Century) or Bethlem Royal Hospital (13th Century), which was also known as St Mary Bethlem, Bethlehem Hospital and Bedlam. These names recall their beginnings, often in religious orders (Davie, 2015: 114), where the obligation to care for the poor, sick and vulnerable was seen as emulating the teachings of Jesus and public expression to their ethical convictions of collaborative healing (Matthew 25:40), social reform and devotion to God (Beal-Preston, 2000). Although these organisations continue to bear the names of their religious heritage, paradoxically their theistic identity has been largely lost within these technological,

rationalistic and secular organisations but remains in the provision of hospital chaplaincy, the architecture, staff and patients who utilise hospital services. Modern healthcare dominated by hospitals and public health professionals have become the established temple-churches and priests of Western society as they legitimise of what it entails to be human beyond matters of physical health. On interacting with hospitals or secular health institutions, certain health professionals and members of the public struggle with the sense of remaining whole. This personal division is a result of the gulf felt between these action guiding worldviews of Christianity and public health healing and the lack of integration or interdisciplinary collaboration for health improvement across these worldviews (Lambourne, 1995: 125).

What is required, is a more critical mutual dialogue on health, illness and healing between public health and religious communities to appreciate the complex wholesome reality of each action guiding worldview (Pattison, 2013). It is such contentions around collaborative healing that have led to the initiation of this study, which will investigate the prospects and problems of collaborative healing between religious and secular healers.

The Christian Church and other religiously inspired healthcare providers throughout the centuries have provided collaborative health care provision in response to the health needs of their communities, alleviating disease and distress (Pattison, 1989: 148). Religious and faith groups continue to deliver a substantial volume of healthcare both nationally and internationally due to their ability to impact and influence community and individual health holistically; socially, physically and spiritually. The collaboration of religious health care providers working alongside state health care provision can enhance population health outcomes, where

community health needs are aligned to these providers of health care (Duff and Buckingham III, 2015).

Religious and faith communities have since ancient times and continue to be instrumental to the philosophy of health, illness, healing and healthcare delivery (Jones and Pattison, 2013). However, since the increasing recognition of the separation of the mind and the body through Cartesian dualism (17th Century), resulting in the body viewed as an inanimate mechanistic entity with no teleology, the divorce of medicine from religious oversight has dominated major healing systems (Gendle, 2016). As a result, the bifurcation of religion and healthcare and emergence of “modern medicine” can be traced to the severance of metaphysical explanations of illness and to the association with empirical scientific discourse of scientific naturalism and rationalism during the late eighteenth century (Vanderpool, 2008). Current Western medicine non-religious character is predicated on its materialistic perspective towards health and illness, however, its raison d'être is not just regarding the increase in scientific knowledge but to “promote the health of people through the prevention or treatment of disease” (Munson, 1981), which necessitates the inclusion of the social and cultural constructions of disease and illness (Kleinman et al, 1978).

Christianity and public health (a speciality of medicine) are two distinct worldviews that provide explication to the truth and reality of human needs, desires and experiences (Susnjic, 2012). The adherents of these worldviews have their own “really real” faith systems and views of health and illness (Pattison, 2013), such that preventative public health may view illness and suffering as of negative value and apathetic to human social and cultural wellbeing, with death being the worst outcome. Such beliefs may run contrary to the value laden and teleological depiction of illness, suffering and death to many religious traditions where illness and suffering

may be seen as part of the divine providence for humans to endure as the will of God or a consequence of personal, communal or societal sin (Gedzi, 2013). Within the UK's Human Rights Act 1998, Article 9 allows patients and healthcare workers the right to freedom of thought, conscience and religion. The law forbids any form of discrimination; direct or indirect based on religion, belief or no belief. Increasingly patients view healthcare workers as delivers of care which are aligned to their beliefs and morals, as the provision of rights of conscience allows patients the confidence that care provided is in their best interests, free from moral reservations (Kiska, 2018).

Religion and medicine have had a prominent and lasting impression on shaping the values of modern societies and have not just been a polarity of interactions between revelation and reason. The intersectionality of worldviews repudiates the ideal of a purist rational secular worldview underpinned solely by reason and empiricism untroubled by metaphysical and moral disagreements. For example, preventative public health measures raise complex ethical questions that are not susceptible to empirical answers, such as the duties that individuals have towards each other or rationing of finite resources (Nuffield Council on Bioethics, 2007: xv-xvi). The consideration of ethical implications (often omitted) allows the values informing health care resource allocation to be made unequivocal, such as what preventative services should be available and for whom, become clearer (Bradley, 2000: 3-16). Concomitantly, theological beliefs are not irrational or bereft of reason and should be allowed a seat in secularist political and social discussions regarding public policy to express its metaphysical views and creedal affirmations (Biggar, 2015). Interaction of these worldviews throughout history and in contemporary times cannot be seen as a continuous series of decisive transformations (grand narratives or generalisations),

as often perceived, but as a set of ephemeral shifting boundaries (paradigm shifts) with complex relationships reliant on prevailing contextual circumstances. Reification of religion and medicine can lead to artificiality and anachronism, as the boundaries and essence of these categories have shifted with time. As a consequence, as long as religion and science continue to stake a claim in the articulation of the models of human values and reality, it is improbable that their complex and multiplex spheres of interaction will not intersect (Brooke, 1991:1-15).

Public health and Christianity are social realities that share common values of stewardship, inclusiveness and justice, as well as a mutual concern of holistic health and healing (Goldmon and Robertson, 2004). Many religious organisations, including those within Christian denominations can inspire action (social ministries), such as caring for the sick (service) and assuaging suffering as an expression of their faith, however, this faith motivation may often be taciturn (Summerskill and Horton, 2015). Such acts of mercy are the practical faith seeking and understanding actions that allow doing practical theology in ordinary life, i.e. making God present and for Christians emanating the ministry of Jesus (Lambourne, 1963: vii). This public expression of faith through values of justice and dignity amidst the prevailing discourse of secularisation (privatisation of religion) may cause faith to be silent to others due to their depreciation of the religious motivations that drive such altruistic approaches to health and wellbeing (Summerskill and Horton, 2015). Emile Durkheim (d.1917) regarded religion as “an eminently social thing” whilst Talcott Parsons (d.1979) commented that religion does not in contemporary society provide broad social and conceptual structures but rather is a component of the cultural secular sub system of society, where religious and secular identities are construed through differentiated and pluralistic communities (Van Ness, 1999).

Many of the characteristics of public health as a worldview do make it suitable in contemporary society to fulfil the role acquired by Christianity (religion) in the past. Public health policy underpinned by social epidemiology allows healthy policy directives to focus on improving deleterious social factors and can influence focus on health, social and economic inequities (Dew, 2007).The current dominant secular public sphere has resulted in many public health professionals finding themselves with a deficit of appropriate knowledge, skills and language (religious literacy) to fully comprehend the action guiding worldviews and lived experience of many of their religiously affiliated populations and communities (Pentaris, 2018) .

Numeration of religious in England & Wales – Census 2011

The UK Census in 2011 collected information on self-identification regarding religious affiliation. Respondents were asked whether they connect or identify with a religion; regardless of whether they actively partake in practices, such as prayer, or worship. The decision to include such a question within the Census reveals a growing awareness that accurate religious statistics are significant in terms of public policy, with the strong implication that religion is indeed a public matter about which we need precise information to inform policy decisions (Weller, 2004).

The census uses self-identification as a measure of religiousness, which is a soft rather than hard indicator of religious attachment, compared to religious practice or belief. In the 2001 Census, nearly three quarters of individuals in England & Wales self-identified as Christians (72%), which fell to 59% in the 2011 Census, i.e. 13 percentage points decrease. During this same period, there was a 10-percentage point's increase in the people indicating that they have 'no religion'; this rose from 15 per cent to 25 per cent. There are an increasing number of people, particularly the younger generations who are electing to pursue a life that is emancipated from

ideological affirmations of organised religions and devotional regularity towards personalised eclectic systems of spirituality (Van Ness, 1999). There are a range of views to faith that can best be seen in terms of a continuum which moves from a strong commitment to the religious at one end to an equally strong commitment to the secular, or to no religion at the other.

In terms of the minority religious groups, Muslims are by far the largest, however, important point to note is the relatively small size of this constituency in the overall picture. The other-faith communities equate to less than 10 per cent of the population as a whole, however, within the UK there is great geographical variation in these proportions.

The overall inferences that emerged from the UK Census 2011 regarding religion concluded that the UK remains a Christian country in terms of history and culture. However, major sections of society are becoming not only more secular but also increasingly critical of religion. An interesting indicator of this adjustment can be discerned by the reaction of people to religious controversies, such that during the 1980s the discussion was largely about the unwarranted intrusion of the church in political affairs, while in contemporary times, the discourse of conflict concerns the competing rights of secular and religious constituencies (Davie, 2015: 37).

It is not true that religion was once firmly privatised and has now suddenly become a public phenomenon, but it is true that it has now become visible in new ways that has provoked a wide variety of responses. A new configuration has emerged where the religious and the secular are more consciously articulated and a visible mutation in religious life has occurred, i.e. a transformation from specific devotional behaviour to an experiential socially constructed wholeness culture. There is the need to be

cognisant of the wide range of positions within the secular and the religious; from the conservatives to liberals.

Public health and Healthcare provision in the UK

Contemporary healthcare provision (healing from illness) within the UK is on the whole provided by the NHS, which was established in 1948 (Woodhead, 2012: 21). More than seventy years later, the NHS remains the major national and local hallmark for therapeutic healthcare and the major driver for health policy development and debate. Within England, the upstream and preventative functions of health improvement are conducted predominantly by Public Health England (PHE) – which is an executive agency of the Department of Health and Social Care. Current policy from the government on public health and its interaction with local communities was outlined within the 2019 NHS Long Term Plan (NHS LTP) that outlined proposals on how the government and the NHS will support wider social goals and improve the health the nation through influencing and shaping local communities (NHS, 2019: 116-120). The current economic conditions within the UK, such as the sustained time of current reduced governmental spending measures, marked by declining public sector budgets has required the UK government to look beyond the NHS for healthcare provision. The emergence of certain faith and community based organisations as partners or replacements for state providers has witnessed substantial growth in social action of churches partnering with non-religious organisations (Demos, 2019: 5). Policy guidance and research evidence on the benefits and barriers of such collaborations is limited; however, research has shown that such partnerships are able to form effective programmes and manage resources economically to enable them to tackle health disparities (Kegler et al, 2010).

The overt medicalisation and clinicalisation of Twenty-First Century health has led to the domination of the healing of the individual body, with scant consideration on how the search for what it is to be fully human. The body and soul is constructed through pluralistic worldviews determined by where people live, grow and work i.e. social (sociological) and cultural (anthropological) construction of health and illness. Despite the historical encounter and collaboration of Christianity and public health, there is a need in contemporary times for a critical dialogue to reconcile understandings of health, illness and healing. The late 19th century emergence of modern public health contagion worldview typified by cessation of Cholera outbreak at Broad St London was possible through analytical and social epidemiology. The oft cited protagonist Dr John Snow (d.1858) epidemiological mapping of the cases (analytical epidemiology) and subsequent successful intervention was immensely facilitated by the seldom quoted local parish curate Reverend Henry Whitehead (d.1896) who provided the neighbourhood intelligence (social epidemiology) of the lives of local residents (Gunderson and Cochrane, 2012: xvii).

The provision of hospital chaplains and faith leaders that offer prayers with patients and health professionals is provided within the NHS. Recognising the importance of social and cultural determinants of health the General Medical Council (GMC) has issued ethical guidance on good medical practice (General Medical Council, 2013:16). The Department of Health (DH) acknowledges that the worldview of belief system of patients constitute a crucial role in the healing process (DH & EHRG, 2009:32). Although the GMC guidance recommends the patient assessment to take account of religious and spiritual factors, these aspects are often excluded (Tomkins et al, 2015). The interpretation of health and illness of some individuals, who regard suffering as a period of learning and disclosure may want the suffering to pursue and

not be eliminated. This conflict between clinical judgement and theological view of illness requires sensitively and cognisance. Cultural and religious beliefs may be potential sources of moral and therapeutic support amidst the suffering and healing during ill health (Hordern, 2016). The chasm between religious and secular bioethics on health and healing can be bridged only through the critical dialogue of clergy, clinicians and patients. By vacating solitary unidisciplinary silos, clinicians and clergy can facilitate addressing the intersectionality of the patient's synthesis of ancient traditions (revelation) and complexities of modern medicine (rationalism) understanding of illness and pluralistic health seeking behaviours for individuals and communities (Jotkowitz and Glick, 2009).

Within organisational contexts, the UK can be described as a complex admixture of vistas of religious vitality and pluralism as seen in workplaces, universities, prisons and healthcare organisations (Cadge and Konieczny, 2014). Religion even within secular institutions, such as hospitals has never actually gone away, but is "hidden in plain sight" in the lives and work of individuals. The provision of recognised religious provision of chaplains within hospitals has been present since the inception of the NHS. An individual's religion cannot be emancipated from the institutional provision and delivery of health care as patients, professionals and carers are members of faith communities. The interaction of religious and secular ethics are implicitly and explicitly present (Pattison, 2013). Making religion more visible to inform and understand action within a dominant secular preventative healthcare environment requires an understanding of the complexities, intersectionality and bricolage of meanings that religion may hold at an individual and social level in relation to health, healing and illness. It also needs to be acknowledged that religious beliefs play an important role for some but not for all (Jones & Pattison, 2013).

The intersection of faith and health sectors to provide health promotion and disease prevention programs remains underused (Levin, 2014), with research suggesting that primary, secondary and tertiary prevention of chronic conditions, such as cardiovascular disease and cancer can be initiated and delivered through congregational communities (Bennett and Hale, 2009: 9-14). Due to their localised presence, support and ease of access for adherents, faith organisations can conduct effective primary prevention through education on risk reduction, secondary prevention via screening programmes and tertiary prevention by improving understanding of disease management and complications (Brooks and Koenig, 2002).

In terms of research on the interaction of the worldviews of Christianity and public health, interdisciplinary investigation of health and faith remains a marginal activity within Western and UK intelligentsia due to a lack of theoretical grounding, as academics from divergent disciplines work predominantly in isolation. There is a paucity of guidance from within the respective lenses of religion and medicine on how to reconcile their perspectives on what makes for health, wholeness and wellbeing (Levin, 2018). In order to tackle this lacuna, the aim of this thesis will be to investigate the interconnections between public health; a speciality of medicine that focuses on preventing ill health and from the Christian perspective of ill health to identify opportunities and obstacles for dialogue and collaborative healing.

Aim of the thesis

The main aim of the thesis was to evaluate and critically appraise the following question:

What are the opportunities and obstacles for dialogue and collaboration between the action guiding worldviews of Christianity and preventative public health in the United Kingdom?

The problematic under scrutiny within this thesis is interdisciplinary in nature and will therefore examine it through the lenses of the two disciplines of religion (Christianity) and health (public health).

Its objectives were to:

1) Examine the ideologies of public health and Christianity towards health, illness and healing
2) Conduct a heuristic selective intellectual archaeological review of the interaction and historic responses for depression and HIV/AIDs from a public health and Christian perspective.
3) Identify opportunities and obstacles that emerge from the review to highlight factors that can facilitate or hinder collaborative healing through investigating the dialogue between historic, social, public health and theological narratives and discourses
4) Create a logic model that outlines activities, outputs and outcomes to strengthen collaboration
5) Create a self-assessment protocol on how dialogue may be initiated between public health and the church in a local area to facilitate collaborative healing for the local community

This research will examine the interactions of healing from two worldviews (Christianity and public health) in order to gain insight and understanding to illuminate the prospects for collaboration of public health services and religious

institutions and ideologies in the UK. Following on from this introductory first chapter, this interdisciplinary thesis will consist of a further five chapters. The second chapter will be the methodology chapter. This will initially explicate the justification on the usage of the intellectual archaeological lens to examine the historical, religious and secular responses to two illnesses; depression (mental health) and HIV/AIDs (sexual health). This archaeological approach will endeavour to understand or cast a critical light on contemporary relations between the institutions and ideologies of healing and health and those of religion, to see how they have related in the past. I am using this approach to generate insights and questions for contemporary understanding. It will also give an explanation for the utilisation of the practical theological, theological reflection and critical conversation approaches that were conducted within the two case studies (depression & HIV/AIDs) to elucidate the opportunities and obstacles to collaboration.

Chapter three will consist of two sections and examine the ideological perspectives of health, healing and illness from a public health and Christian viewpoint. The public health section will analyse the transitions of this specialty across the ages and how societal influences have caused it to perpetually evolve in response to current technological advances and health challenges. The Christian healing section will examine illness and healing in the Bible (Old and New Testaments), as well as the healing ministry of Jesus in the contemporary UK context. Due it being a selective analysis, responses to illness will not cover all different churches or denominations, where “the church” will refer to it as an institution and not an ideology. Healing is a persistent theme in the history of Christianity with scriptural references to illness, heath and healing in both Testaments. Ministering to the sick was a major vocation of Jesus, however, the aetiologies of individual illness or suffering was paradoxical,

as it could be rooted in the sin or malevolence of the individual or benevolence of God to aid spiritual enhancement.

Chapter four will consist of the examination of two case studies; depression and HIV/AIDs. The critical conversation will consist of a number of interlocutors. Each case study will be viewed through a historic, social, public health and theological lens. This intellectual archaeological review will allow the identification of challenges and opportunities that either helped or hindered collaborative healing between religious and health partners. The engagement of the complex interactions of science and religion will be investigated in their relative social and political contexts, highlighting the notion that both are not reified entities with timeless essences. The accent will be to transcend the generalisations in order to relish in the differentiation and complexity to provide a critical perspective of institutional and ideological relationships.

Chapter five will present the findings (opportunities and obstacles) from the intellectual archaeological examination of the case studies of depression and HIV / AIDs to highlight factors that can facilitate or hinder collaborative healing. The chapter will contain a logic model that will be developed from the emergent themes of the intellectual archaeological review of the case studies. The model will outline interventions that maybe implemented in practice to increase collaboration across the religious and health sectors. The chapter will culminate with a set of questions and considerations local areas could work through in order to instigate the dialogue between preventative public health in the local authority and Christian healing in the local Church.

Chapter six will outline the salient conclusions from this study and will be followed by an individual chapter reference section.

METHODOLOGY

Outline of Chapter

This chapter will begin by considering the role of religion as a critical determinant of health. It will then review the deployment of the intellectual archaeological approach to comprehend relations of health and faith organisations in the past in order to illuminate prospects for the future. Following this will be an explanation of the practical theological approach that the thesis will follow to complete this study. The chapter will close on a reflexive note on my journey and aspirations for adhering to a practical theological approach to conduct public health research.

Religion – a social and structural determinant of health

Public health's raison d'être is centred on enhancing population health through preventing illness and prolonging life. This requires the minimising of health inequalities between groups within these populations and necessitates the attention to the wider social and structural determinants of health. Improving health within populations / communities is a continuous quest (Gunderson & Cochrane, 2012: 169-170) that integrates social, psychological and physical interactions, through relationships with historical and contextual ideas and institutions. Religion and religious institutions are key social determinants of health due to their ability to influence beliefs and behaviours of adherents regarding their loci of health activity (Wolpe et al, 2014: 410). However, the role of an individual's religion on their health or religious communities' participation in health care provision (social capital) through providing access to health services (structural) is seldom assessed when local public health policy is devised (Karam et al, 2015). The precise role and action of religion on health is complex, as the mixed health seeking modalities of individuals may concurrently hold both a belief of traditional healing practices as well as modern

biomedicine. It is for this reason that the dominant contemporary NHS clinical model of healthcare is being challenged due to its exclusion of the holistic nature of health and to incorporate a whole person biopsychosocial model of health and wellbeing (Havelka et al, 2009). The appreciation of the nexus of religion and health has become a strategic necessity and tactical advantage for health improvement due to the more holistic approach to health and illness that it considers, such as the physiological, psychological, social and spiritual dimensions. Religion, medicine and the provision of healthcare have been associated with individual and population health since time immemorial (Koenig et al, 2012: 15-34). As per the aim of this thesis, I will be investigating and appraising the interaction between two action influencing worldviews of Christianity and preventative public health regarding health, illness and healing to illume factors that will engender dialogue between these two disciplines to influence actionable health improvement policies and improve health outcomes.

In order to develop efficient and effective population health improvement policies, it is necessary to comprehend the circumstances that inspire or impede health improvement actions of the public in pluralistic healthcare systems (Shaikh and Hatcher, 2004). Religious beliefs and behaviours are often intertwined with social and cultural praxis and superimposed on individual praxis, therefore unravelling the underlying motivation of health improvement action are challenging; medical or metaphysical? (Summerskill and Horton, 2015). Elucidating the exact impact or mechanism of religion on an individual's health and healthcare is complex (Kirn, 1991). The factors that inspire a person to a specific choice in health care matters can be assessed by the Health Belief Model (Rosenstock et al, 1959), while the religious problem solving coping scale (Pargament et al, 1988) can allow

categorisation (self-directing, collaborative, deferring) of what role religion plays when individuals process life events. The self-directing style of coping individuals within this scale deduces that individuals with this style take full responsibility for problems, without taking support from a transcendent source, while the collaborative individual turns to God for assistance in times of adversity. The deferring personality type accedes responsibility to God and eschews all responsibility of problem solving. These responses lie within the life and healthworlds of individuals and communities, reflecting their cultural, religious and linguistic constructions of health in which they are embedded (Germond and Cochrane, 2010).

The examination of the relationship between faith and the health has been increasing recently across many academic disciplines. The investigations have revealed how religious phenomena within theoretical and conceptual frameworks affect health outcomes and validate the multidimensional aspects and impacts of religious beliefs and behaviours that manifest via biobehavioural and social-psychological models (Chatters, 2000). However, if there is endorsement of the view that health professionals and clergy can collaborate to provide collaborative healing, a plethora of who, what and why questions arise.

- Who should be involved and what form of involvement should it entail?
- What type of religious information is relevant; general or specific?
- What is the role of the religious / health professional in these interactions?
- What are the patient preferences in these religion / health interactions?

It is essential that professionals and the public from multiple world-views commence discussions on these questions, as without this dialogue it will be impossible to reconcile any differences that may emerge from the religious and scientific worldviews on the nature and meaning of collaborative healing. The following section

will examine whether a practical theological approach can facilitate this dialogue between Christian healing and public health.

Practical theology

This study will be of an interdisciplinary (Christianity and Public Health) and dialogical in nature. It will attempt to correlate historic and contemporary understandings of health and illness from the Christian and preventative public health perspective for the purpose of applying this phenomenology or lived experiences to stimulate dialogue in contemporary times to tackle current public health challenges. I will employ a practical theology methodology to critically reflect on the interactions of collaborative healing for the two case studies that I will be studying in detail. The case studies will consist of deep dives into depression and HIV / AIDS to allow the explication and appreciation of the connections between beliefs and practice through a process of (critical conversation) theological reflection (Thompson et al, 2008: 3). This dialogue will be broadened by adopting an intellectual archaeological and pragmatism approach advocated by American philosopher Richard Rorty (d.2007) that allows an intellectual conversation with many disciplines, with the aim of achieving mutual understanding to resolve contemporary challenges (Hernandez, 2017). Rorty viewed scientific knowledge as a set of contingent vocabularies which people abandon or adopt over time and rejected knowledge that was just a mirror of nature. He conceived beliefs as habits of action that are justified in a particular time to the purpose of a culture of community. This represented a shift from epistemological to ethical-political concerns in scientific practice, involving a complex matrix of interactions and relations that where perpetually constructing and deconstructing (Rorty, 1991:94). This dynamic instrumental approach will allow the emergence of insights from cultural and socio-

political perspectives and reveal the barriers or beneficial features for dialogue across historic health and healing systems.

Theological reflection forms the focal point and is the pivotal axis of practical theology (Pattison et al, 2003). Practical theology has been defined as:

“A place where religious belief, tradition and practice meets contemporary experience, questions and actions and conducts a dialogue that is mutually enriching, intellectually critical and practically transforming” (Pattison and Woodward, 2000:7). The claim of theological reflection is its capability to respond to the challenge of systematically connecting and addressing the lacuna between theoretical theology and praxis of faith. Theological reflection is perceived by practical theologians to be a useful activity for practice as it; facilitates critical relevance of theological ideas so that they do not become anachronistic, has the ability to transform situations, persons and understandings in order to enliven and enhance contemporary practice that allows practitioners to explore interdisciplinary inhabited worldviews (Pattison et al 2003). I will be adopting the “critical conversation” model of (Pattison, 2000: 136) as a methodology to entangle the complex relationships between religious faith and practical action. This entree into theological reflection can be seen as engaging in a tri or multiple partite conversation between a faith tradition, one’s own faith presuppositions and a particular contemporary challenge. The advantages of this model of conversation is that it allows one to reflect on practice and allows the personification of participants that may be emanating from different starting points. The conversation can engender heuristic enquiry, allowing the interlocutors to discover new ideologies and perspectives. This method also allows the decomposition of complex modern

situations, so that they can be tackled through creative interdisciplinary solutions rather than be stifled by orthodoxy.

Christian theology has always been a practical “faith seeking understanding” endeavour arising from the experiences of daily living and the commitment to one’s faith in relation to broader social and cultural circumstances (Ballard and Pritchard, 1996: 1). Practical theology as a discipline resides on the boundaries and frontiers of other fields of learning and practice and is therefore suited to creative opportunities of interdisciplinary dialogue. This residency allows it to make connections and view reality as a whole system and discover new lands of possibility and prophecy to contemporary tensions within practice of daily Christian life (Bennett et al, 2018: 104-107). Given that preventative public health revolves around time, place and person in terms of health improvement, a practical theology approach to solve individual and community health issues is well aligned due to its emphasis on contemporary enquiry and holistic approach. Reflective practice is not new to the discipline of public health and health improvement, as it constitutes one of the core components of the UK Faculty of Public Health (FPH) continuing professional development (CPD) programme. The requirement to critically and systematically reflect within both Christian theology and public health is essential, as it will prevent one to fall into a solipsistic rut and embodying an uncritical and resistant mindset (Pattison et al, 2003).

Practical theology is a diverse activity and has grown as a subject, becoming more complex and critical in its methods, reflection and reflexivity during the last few decades (Bennett et al, 2018: 1). It offers a research perspective, where findings are contextually informed and generates practical wisdom (*phronesis*) and creative possibilities (*poiesis*). In this way, practical theology research allows locating the

activities of life, theology and practice within inhabited action guiding world-views to enable a fuller understanding of obstacles and opportunities of human flourishment (Pattison and Edgar, 2016).

Practical theological transformation is a part of Christian life, where the ability to do theology (God consciousness) whilst in the midst of life requires reflection, renewal and reform. However, any path to profound alteration typically manifests through a multistage process that requires movement from comfort to challenge zones. Such a 'Matthew 28:16-20 journey' necessitates transformation and kenosis (self emptying). Such practical transformation within institutions requires liberation from the shackles of institutionalism, as this leads to decay and demise and it is only through shifting empowerment to congregants that a missional theology can drive transformation and understanding of the interaction between Word (Bible) and world (daily life and vernacular culture). The postmodern world is moving on from the prominence on singular rationalism / causality and individualism to nascent complex notions of identity, authority and communities (Hendriks, 2017). Doing theology within and outside of the church during this era (new world) requires a new church (McLaren, 2000: 11). The emergent theology needs to be interdisciplinary, contextual and done 'from below' breaking from the epistemological shackles of the Enlightenment empiricalism (Bosch, 1991: 423-425). The sustainability of this transformational journey requires empowering and serving leadership to develop 'uploading' and frontier crossing (Friedman, 2007: 95).

Multi and interdisciplinary research are particularly difficult because of the tendency of one to be constantly lured back into their own areas of expertise and customary ways of thinking (Pattison, 2007: 20-21). Interdisciplinary research arises from the cognisance of the existence of persuasive queries that are unable to be

comprehended through the perspective of a single discipline (Nature, 2015). Interdisciplinary research is stimulating and enjoyable as exploring the complexity is a response that can best provide understanding and insight of how for example the divine and daily life are practiced, i.e. how human action manifests as they inhabit the spheres of secular and sacred worlds. The entering into new worlds can provide opportunities in which transformation and discovery of new insights reveal themselves out of the complex and intersectional social processes within everyday contexts (Bennett et al, 2018: 23). The unbalanced perception, blinkered professionalism or fundamentalism of clinical curing from sickness / preventative public health and confined ecclesiastic ministry of healing has led to a cessation in interdisciplinary dialogue between the Church and public health. In order to escape these one-dimensional theories and traps, there is the need to speak the other's language and view reality through pluralistic worldviews and navigate the conceptual difficulties that may ensue (Lambourne, 1995: 105-106).

A reflexive note.

Practical theologians consciously explore the features of their own action guiding world view in order to become critically conscious of the habits, philosophies and actions of the world view that guides their perception and action. In this reflexive mode researchers are changed by their own research as it permits more creative action and engagement within that worldview due to information gained and nascent conceptualisations being born (Bennett et al. 2018: 30). These insights of reflection and reflexive practice should not imitate or mirror current context but allow transformation and vision for direction of travel. As the world is understood though our engagement with it, meanings and creative practice emerge from new understandings of humanity through transformation of what was known previously.

The process and journey of this transformation provides valuable and enlightening wisdom that continues beyond the point of production. Practical theological research involves a complex conversation about complicated human experiences.

Practical theological research affords priority to the contemporary experience, i.e. nothing is more important than the present. Attending to contemporary experience deepens experience and understanding and allows theological inquiry to be relevant. Given that the divine presence is ubiquitous, grace or revelatory experience may be experienced in everyday human experiences. This sacramental worldview that sees immanence in all things constitutes the potential of the disclosure of God to humans in all sciences and disciplines of learning; theologising every step of life.

Practical theology for me has provided a home for my intersectional action guiding world-views of Islam (religion) and public health (vocation). Enrolling onto the MPhil programme in 2016 within the department of theology and religion, I wanted to investigate the relationship between religion and health. This interest had stemmed from a personal interest but also from the increased vocational interest of public health to partner with religious and community groups as vehicles to population health improvement. Approaching this interdisciplinary investigation, I soon realised the difficulties of conducting this type of research and finding academics that had experiences and interest of public health and religion. I decided to examine health, illness and healing from a Christian perspective as this had the largest evidence base within the UK. Being am adherent of Islam, this was a challenge for me, as I had to learn the worldview of health and healing from a Christian perspective. It was towards the end of the second year that I began to explore the possibilities of using a practical theological approach as my main methodology to elucidate opportunities and obstacles of the collaboration between Christianity and public health. The initial

inertia I was experiencing within public health practice regarding investigating community based health improvement was also receding, as the zeitgeist within the political world was transforming to more outsourcing and community based health interventions due to the financial pressures of austerity and the rising welfare bill on the state.

Practical theology has provided me a methodology that allows transformative practice to be developed. The critical conversation approach allows dialogue to take place between individuals of differing world-views, where the object is to address a contemporary issue, be it within the secular or religious realm. For me, the learning of this approach has provided me has been to appreciate the complexities of life and the importance of reflective practice. The interdisciplinary dialogue has made me more aware of the wider determinants of health and wellbeing that impact on the individuals and communities. Theological reflection has provided me a means of exploring and evaluating through active dialogue questions and challenges that arise from the interaction of these complex worldviews to produce transformative, coherent and epiphanic ways of moving forward. There was also the realisation that certain dominant societal frameworks need to be considered, such as secularism, scientism and stigma that are often ignored by both the Church and Public Health, when considering health, illness and healing. I envisage the learning and findings from this study will aid me in my work on engendering the dialogue between faith and health. It was for this reason, I was keen to develop a logic model on collaborative healing and self-assessment, so that it may be able to facilitate conversations that I or other health professionals may have with those formulating public health policy. I also see the wider application of the practical theology approach to other challenges and issues within the world of public health. The way

forward to understand the realities of life I believe is to engage with reality through a contextual, collaborative interdisciplinary framework.

IDEOLOGICAL PERPECTIVES

Outline of Chapter (Part 1) - Health and healing in public health

This section will evaluate the major transitions of public health through the historical ages in terms of its approach to health and illness. As a speciality of medicine, it has followed a similar trajectory of reductionism that focuses on disease eradication and seldom investigates the wider determinants of health. Although there have been substantial health improvements with the UK, such as increases in life expectancy, figures from the last few years have shown a stalling of this increase. Public health is still trying to tackle the relatively new dominant paradigm of non-communicable disease and is increasingly operating through a complex community whole systems model.

Foundations of public health

Public health and its cognates; public medicine, preventative medicine, community medicine, public hygiene as a discipline have subsisted since the existence of the earliest human civilisation (Brockington, 1960: 3). This stated inception of public health is contrary to its ostensible depiction in many historical narratives of it emerging from nineteenth century advancement of sanitation or Public Health Acts in Victorian England, as problems of disease, disability and destitution have been present throughout history (Rosen, 2015: 1). Having said that, public health is often defined reflecting notions of nineteenth century ideals of sanitary and vaccination reforms. This historiographical tradition gained traction following post World War II publication of grand narratives (old public health), through (Sand, 1952; Rosen, 1958) who wrote on the termination of endemic and epidemic diseases by the technological advancements of science and medicine. This myopic understanding of public health evolved, leading to the development of new historiographical

methodologies and application of postmodernist public health theory that included notions of the impact of socioeconomic and political responses to ill health (Coleman, 1982). As a result, rather than a singular ideological perspective, a multicultural mix of voices have emerged and contributed to the current new public health paradigm. These diverse voices have reflected the intellectual and philosophical approaches to the changing relations of illness, diseases and sickness with society (Porter, 1999: 4). Accordingly, what constitutes public health has been redefining itself throughout history and been dependent on the relativism of the collective action of society and community life to ameliorate the health of populations. It is therefore evident that the concern with community health through provision of good quality food, water and housing has existed throughout human history and therefore the narrative and discourse of public health predates ideals of Victorian England.

Public health as a term emerged was coined in the nineteenth century to distinguish the collective actions governments could undertake to protect its population from ill health and from the actions of private individuals to improve their health (Heller et al, 2003). One of its perennial tensions has been one of definition, where it risks being everything; the air we breathe, the food we eat, sanitation or nothing but a collection of ideas (Griffiths & Hunter, 1999: 1). Within the UK, the common contemporary definition of public health is as formulated in the Acheson (1998) Committee Report; “the science and art of preventing disease, prolonging life and promoting health through organised efforts of society”. The major issues with this definition is the open-ended nature and interpretation that it imbues. Other deficiencies include, the omission of the public and absence of any specific praxis to those responsible for public health functions to meet this definition. Many other definitions exist:

- UK Faculty of Public Health[1]: "The science and art of promoting and protecting health and wellbeing, preventing ill health and prolonging life through the organised efforts of society"
- World Health Organisation[2]: "The art and science of preventing disease, prolonging life and promoting health through the organised efforts of society"
- Charles E. A. Winslow[3]: "The science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private communities and individuals"

Some of the definitions incorporate elements of community and instigation of social changes (which themselves require defining), however, they often fail to explicate the political, religious, economic and individual power relationships and beliefs that exist and are essential for transformative social action to improve population health. Heller et al (2003) propose a definition, "Use of theory, experience and evidence derived through the population sciences to improve the health of the population, in a way that best meets the implicit and explicit needs of the community (the public)"'. This characterisation has greater utility, compared to those mentioned previously as it incorporates the public and outlines the required methodology for praxis. For public health to address the major challenges of ill health in contemporary times, it needs to ensure that it recognises the centrality of the public in its practice, so that it can

[1] https://www.fph.org.uk/media/1304/good-public-health-practice-framework_-2016_final.pdf - Accessed 2nd June 2020
[2] http://www.euro.who.int/en/health-topics/Health-systems/public-health-services - Accessed 2nd June 2020
[3] Winslow, C. E. A. (1920) The untilled fields of public health. *Science* Volume 51 No.1306 23-33

better understand the values and worldviews of the communities, resulting in the provision of appropriate healthcare delivery.

Public health as a function can be seen as the concerted and systematic approaches by society to protect, promote and restore people's health (Last, 1995: 134). It is underpinned by the science of epidemiology, that studies patterns of morbidity and mortality across populations. As a worldview, it is about facing health problems as an individual, community or population and using organised communal or population approaches to resolve those problems. It can be viewed as a kind of bricolage of communitarianism, utilitarianism and egalitarianism enacted through the science of social and clinical epidemiology. Public health also promotes a common good that assumes implicit principles of community and equality, although these value laden first principles are seldom explicitly stated (Beauchamp & Steinbock, 1999: viii). As a profession; public health can be considered to be consisting of a host of different professionals, interests, stakeholders and the public. Public health as a discipline or science has throughout history undergone numerous ideological and technological transitions due to societal advancements and perceptions of health and disease (Berridge et al, 2011:2). Ideologically, public health is never static and under perpetual transformation, as many of its evolutions can be concomitant to the socioeconomic, historic and governmental ideas on health and wellbeing during these ideological shifts (Hanlon et al, 2011).

As an action guiding world view, public health is multiplex and interdisciplinary in nature, that encompasses a variety of interpretations, ideas, values and actions of professionals and the public (social action) concerning the health and life of communities (Richman, 2003:3). Improving public health through social action is therefore a multispectral and multidisciplinary undertaking. The precepts of public

health can be thought to be constituting of three categories of thought. The first category characterises public health as a moral enterprise, which denotes that maintaining good health and avoiding illness is a moral duty to maintain good health. Burls (2000: 148) remarks on how professionals working in public health attempt to attain concentrated health gains by adopting utilitarian philosophies as a framework to inform their preventative public health policies, i.e. a duty to longevity of life. Brown (2015) questions the current focus of medicine and public health on adding years to lives, as the extra years are often of poor quality. Rather than concentrating on the causes of mortality, a focus on the causes of ageing and age-related morbidity will enable a better quality and end of life. The practice of public health also consists of a prescriptive category, synonymous to many religious decrees, as it orders individuals / populations to do certain things and avoid others. In this way, the public health lens visualises the world through the likelihood of illness by assessing risk and protective factors. Finally, an analytical category public health characterises the discipline and enables it to demonstrate the validity or effectiveness of health interventions to inform prioritisation of finite resources for a reasonable level of health for individuals. The basket of these factors are under constant revision (Richman, 2003, p, 8), relative to advances in science and research and 'spirit of the age' norms.

Development of public health practice

Ancient medical systems explained disease, illness and healing predominantly through religious, magical and mystical aetiologies (supernatural), although empirical methods (natural) were also used. Physical health was associated with moral wellbeing and the praxis of spiritual exercises, propitiations and libations were aimed to purify the body and the soul before God(s). Health and cleanliness helped to

eliminate spiritual defilement for the patricians in Ancient cultures and it also provided the ruling elites the legitimacy of their social status. Hippocratic medicine (460-361 BC) attempted to shift the dominant paradigm of disease aetiology from supernatural to natural causes (humoral physiology). Sickness and disease were categorised empirically, with consideration given to environmental determinants and therapy based on clinical observation and appropriate regimens of prevention, such as diet and exercise (Porter, 1999: 11-17). The regiment of the six non-naturals or innate factors[4] and seven naturals[5] were interwoven through personal and public hygiene to prevent the spread of disease in an effort to provide a salubrious spiritual, physical and social environment for the community.

As social orders began to transform through the demographic transition between the eleventh and fifteenth centuries from agrarian to industrial urbanised societies, the health of the diseased poor became to take greater significance than the patricians. The new methods of agriculture developed during this period resulted in the population across Europe increasing threefold (Porter, 1999: 27 & Garman, 2007: 23). The shift and transitions in these social, demographic and economic factors produced new opportunities for the spread of infectious disease, such as; plague, leprosy and tuberculosis. Leprosy caused the greatest suffering, as since Biblical societies, lepers were separated from the rest of society (Leviticus 13:45-46 and Numbers 5:1-4). The leper lived but was socially and legally dead, as the stigma of excommunication was not necessarily due to fears of contagion but leprosy as an insignia for moral corruption and punishment for sins. By the late middle ages, municipal regulations regarding sanitation refuse removal and commercial behaviour

[4] air, exercise and rest, sleep and wakefulness, food and drink, excretion and retention of superfluities and the passions of the soul

[5] the elements, the temperaments, the humours, the parts of the body, the faculties, the functions and the spirits

(food hygiene) began to be enforced across many European cities. The intermittent plagues of bubonic plague (Black Death) stimulated the growth of bureaucratic government and power of civil political authorities that attempted to maintain social and economic stability, as well as public order, amidst the ravaging mortality, e.g. 1/3 of European population ~ 20 million was killed due to the Great plague. These civil administrative structures to ameliorate the effects of the plague emanating during the Renaissance within the nascent European states became a model for public health administration across Europe (Porter, 1999: 30-37).

The control of pestilence and plague across Europe during the late medieval and renaissance periods gave rise to the creation of modern health politics and healthcare systems through public health officials, boards and health regulations to regulate measures to control the plague (Tognotti, 2013). Many of the health administration policies of controlling the plague-imposed emergency measures upon local communities and required localised urban political structures to implement these measures, something that was absent in Renaissance (14th to 17th Century) England. The Plague Act (1604) in England adopted European quarantine regulations of plague control and a set of orders that coincided with the aims of the Poor Law and other measures to reduce social instability (Porter, 1999: 42). The stability of Europe and rise of Early Modern European nation states during the seventeenth century as described by Voigtlander & Voth (2013) was as a result of the “three horsemen of riches”; the plague, urbanisation and war. The end of the European Wars on religion or Thirty Years War and following Treaty of Westphalia (1648) instituted the basis for the sovereign states in Europe by confirming diplomatic independence of secular rulers and curtailing of the Pope’s universal claim of authority under the Holy Empire (this was part of the Protestant

Reformation) by recognising religious diversity (Croxton, 1999). This rise of centralised government within nation states was paralleled by growth in public health administration as the power of the state was determined by indicators of population health (Rosen, 1974), giving rise to the importance of biopolitics of the individual, community and society.

The growth of public health during the eighteenth century across nascent nation states of Europe led to the incipient notions of national health systems gaining momentum, with initiatives such as printing was utilised to address public health concerns regarding plague travel restrictions. As formative governmental public health initiatives across Europe were exemplified by medical policing and monitoring, governments used print as a means to disseminate and communicate public health strategies to the populace to enforce legislation and regulatory mechanisms (Bamji, 2017). The dominant political philosophy of European states during this period saw the population as their paternalistic property and equated population wellbeing with state wellbeing. This led to the rise of governmentality (Foucault, 1991: 93) were the body and the behaviour of the individual was governed by the state, as it was deemed the economic and political property of the nation (Porter, 1999: 51-53). The late eighteenth century in England saw this civilising process manifest through the improvement of squalid conditions of the urbanised poor through approaches reminiscent of Hippocratic miasmatic environmentalism (relations between environmental factors and disease) to avoid and prevent disease, as well utilitarianism through welfare reforms for the poor and destitute.

UK Public since the 19th Century

Hanlon et al (2011) explicates public health's mutable disposition since the industrial revolution (18th / 19th Century) as four waves that have reflected changes in the

regulation of the modern state. The first wave is proposed to have emerged at the beginning of the industrial revolution and was structural in nature. There was recognition that overcrowding, lack of clean water and poor housing in burgeoning urbanised cities created an ideal milieu for the propagation of infectious diseases. Chadwick (1842) demonstrated the relationship between living conditions and disease, which led to the creation of major reservoirs in UK cities to provide clean water. The Public Health Act (1848) acknowledged the seminal roles of local and national governments in improving population health, giving rise to the preventative and community health infrastructure within municipal authorities through the role of medical officers of health (MOH). This structural top down approach was significantly influenced by advances in scientific discovery (Davies et al, 2014), as miasmic theories of disease were being questioned and the causation of infectious diseases (germ theory) was being formulated through the works of John Snow / Henry Whitehead (Cholera outbreak) and Robert Koch (Mycobacterium tuberculosis).

Advanced aetiological disease epidemic understanding was leading to the materialisation of the “second wave” of public health. This current was characterised by focussing on a biomedical aetiology of illness, disease prevention and therapy through empirical scientific rationalism. The Vaccination Act (1853) legislated that all infants by the age of three months should be vaccinated against smallpox. This legislation was illustrative of how wave one (structural) was interlinked with wave two – biomedical (Davies et al, 2014). The greater understanding of biological processes, aetiologies and the development of analytical and descriptive epidemiological methodologies gave rise to the emergence of public health’s third wave – clinical. This wave was characterised by formation of the English welfare state and post-World War II formation of the National Health Service in 1948 to tackle the emerging

epidemiological transition of communicable to non-communicable diseases. This era was epitomised by the enhancement of understanding the aetiology and risk factors to chronic conditions; heart disease by the Framingham Study (Stoke et al, 1989) and lung cancer by the British Doctor's Study (Doll, 1954). The exploration of risk stratification and screening to prevent disease provided insights to the social distribution of disease. The greater elucidation of risk factors was able to guide preventative measures, such as lifestyle changes (smoking, physical activity and alcohol intake) to reduce the reduce the occurrence of disease. The WHO Ottawa Charter for Health Promotion (WHO, 1986) outlined a pledge to ensure member states formulate healthy public policy that focussed on intersectoral action. Works such as, WHO (2008) – "Closing the gap in a generation" and (Marmot et al, 2010) – "Fair Society, Health Lives"; conceptualise the work of the fourth wave of public health, that have given an emphasis on the wider social, economic and political factors that may cause ill health. Medical interventions, such as antibiotics, heart transplants and kidney transplants during waves two and three may have contributed to the considerable reduction in mortality during the end of the 20th and beginning of the 21st Centuries. The health of the public within the UK has been greatly enhanced due to the impacts and influences of waves 1 – 3. However, the complex context of the fourth wave that has attempted to address two major evolutions in the health of the public of the UK. The first has been the epidemiological transition, i.e. a greater disease burden from non-communicable disease compared to communicable disease and the health services having to deal with chronicity of illness rather than a hegemony of acute episodes, whilst the second has been the greater awareness and realisation of the importance of mental health on physical health. Given the advancements of understandings of disease aetiology and the proximal and distal causes of ill health, inequalities of health still exist within the UK.

Davies et al (2014) suggest the current challenges within UK public health necessitate the requirement of a new (fifth) wave of public health due to the societal shifts and persisting health inequalities. Rather than a top down paternalistic approach, a more shared responsibility of health through greater collaboration of the public and professionals within local communities is posited. This cultural shift of community health is required amidst modern societal emphasis on individualism. There is a need to develop a culture of health, in which health is considered from an interdisciplinary lens that incorporates health improvement interventions from civic, service and community providers (PHE, 2019).This wave requires individuals, communities, public and private health care providers, as well as voluntary organisations to work collaboratively and address multiple lifestyle factors and multiple morbidities. This shift in communitarianism is proposed within contemporary society that idealises individualism, materialism and consumerism, while the previous waves were receptive to “top down” interventions and assigned relative unimportance of the individual and human spirit (Hanlon et al, 2011). This new wave of development therefore cannot emanate from an accumulation of the previous waves but rather requires a substantial shift in worldview or paradigm shift to be implemented and address existential public health issues.

Current UK public health practice

Since 2013, the responsibility and for a number of public health services were reassigned from the NHS to local authorities i.e. national to local government. The return of certain preventative public health functions to local authorities, following its transfer in 1974 to the NHS was deemed necessary to meet the challenges around an increasing elderly population (social care) and the persistent widening of health inequalities. The inclusion of improving health within the local council’s statutory duty

would enable the health and wellbeing agenda to be embedded within their local communities and across all policies that went beyond GPs and hospitals; education, housing and environmental health (LGA, 2019). However, despite these mandated health improvement functions of local government, there have major reductions in financial resources available to public health teams in local areas. Between 2015/16 and 2019/20 the public health grant was cut by £531 million in cash terms, yet it is being legislated by government and the NHS to tackle inequalities and guide the prevention agenda within its communities. Public health today within the UK is operating under a dominant neoliberalism political ideology; a post welfare state model that views “the market model” in public service delivery and welfare as its modus operandi, due to its purported economic effectiveness rather than sole state delivered health provision (Maskovsky & Kingfisher, 200: 105). Public health as a discipline is undergoing substantial structural, cultural and identity erosion in recent times and operating in an epoch of deepening austerity, widening health inequalities and deep cuts to budgets in local government (Chapman and Middleton, 2017). For nearly a decade the NHS has also been experiencing similar erosion due to substantial reductions in funding that has subsequently affected its performance around waiting times and workforce shortages (Kings Fund, 2019). It is envisaged that the new NHS long-term plan (NHS, 2019) will alleviate some of these shortcomings through new funding within the NHS and improve health and wellbeing of the population through greater integration with local government and communities.

Current approaches within public health practice are unable to tackle the persisting challenge of disparities in health status across populations in the UK. The Black report (1980) reported substantial health disparities and differentials in health outcomes between social classes, even after thirty years of a universal health

service (Gray, 1982). Given the persistence of health inequalities, it seems that recommendations from health inequalities reports (Black, 1980, Acheson, 1998 and Marmot, 2010) have been remarkably similar and something of a 'Labour of Sisyphus' or business as usual as inequalities have in many cases widened over the course of these reports. Public health strategies in the past were more inclined to focus on public health hygiene issues to reduce infection transmission (communicable paradigm), whilst the focus in contemporary times is on lifestyle (behaviour change) to prevent the development of long term chronic conditions, such as diabetes or cardiovascular disease, which place a preventable drain on state resources. A healthy person or healthy body is depicted in today's age as a morally worthy citizen who exercise control of their bodies are normalised, whilst those that are unhealthy or outside of social norms are often stigmatised. Healthy active citizens who can manage their own health are often compared to those of ill health and requiring state intervention to demonstrate the gap in health status, i.e. endorsing an individualistic worldview of health (LeBesco, 2011).

Many of the current health promotion strategies operate though a dominant current capitalist culture. This neoliberal rationality draws on principles of minimalist state intervention and individualism, promotes a market fundamentalism approach and equates inequality due to individual choice. Health improvement initiatives in public health promoted through messages that propagate the agency of the individual, disregard the wider societal norms that can influence the health and wellbeing and health outcomes of individuals and communities (Ayo, 2012). They also rely on individuals to exercise individual agency to conform to expert and normative prescriptions of what it is to be healthy However, the value an individual places on their health as a priority requires changes in culture that can be shaped mainly

through social environments and networks and not top down interventions (Harrison et al, 2011).

The 2019 NHS long term plan (LTP) provides a roadmap for healthcare services over the next ten years. The plan however, reflects continuity of the status quo in terms of aims and objectives rather than fundamental change, which is required to tackle some of the major issues of the NHS (Kings Fund, 2019). It recognises that good health is more than healthcare alone and has placed prevention at the heart of each of its key elements. Although the plan acknowledges the responsibility of the NHS in tackling the wider social determinants of health to reduce health inequalities, it lacks firm commitments on harnessing community resources. Implementation plans are required to create a culture of health and wellbeing through an assets based approach by engaging civic and community partners to instigate a system change in health improvement rather than the focus on clinical services and disease management (Chapman & Middleton, 2019). Without whole system investment and genuine vertical and horizontal collaboration between partners across private and public sectors, the plan will be unable to deliver its prevention vision (NHS, 2019).

Outline of Chapter (Part 2) - Christian Health and Healing

This section of chapter three outlines health and healing from a Christian perspective. It will begin by defining health in theological terms and then investigate health and wellbeing within the old and new testaments. This will be followed by an examination of the healing ministry of Jesus. The chapter will finish on the current requirement for churches to be aware of corporate and community healing and the development of therapeutic communities.

What is health in the Bible? What constitutes of physical and spiritual health?

Health in Biblical terms refers to a holistic association with God concerning notions of physical, mental, relational and social wellbeing (Atkinson, 1993). This holistic worldview of health emanates from the definition of the Hebrew word *Shalom* found in the Old Testament (OT) and refers to philosophies completeness, soundness, welfare, peace, health, and wellbeing amongst other meanings. Health is a part of *shalom*; where each dimension of an individual's being; emotional, physical, relational and environmental are open to God. In terms of semantics, the words; sick, sickness, disease and other derivatives occur fifty six times in the OT and fifty seven times in the NT (Olagunju, 2013), emphasising the concern on healing the sick within the Bible. Jesus is proclaimed in the New Testament (NT) as the bringer of *shalom* or wholesome wellbeing as prophesised in the OT (Atkinson, 2011:9-11). The healing and curing of disease and sickness by Jesus (Matthew 9:35) illustrated the health-giving signs of the messianic age, as echoed in the passages in Isaiah (35:5-6). Health is therefore not a one-dimensional corporeal attribute, but rather it is portrayed by Biblical concepts as a multidimensional relational reality that constitutes an individual's relationship with God, other humans and society. Landa (2014) explicates good health as not just the lack of disease or physiological / psychological

malfunction but rather a harmonious relationship in all dimensions of life inscribed in an individual or community. The multidimensional unity of life calls for multidimensional or intersectional concepts of health, disease and healing, but in such a way that it becomes obvious that in each dimension all the others are present (Tillich, 1961). As a consequence of this understanding of health and disease, healing in the Bible is focussed not only on the functional restoration of diseased or damaged parts of the body but rather a renewal of the holistic state of well being and relationship of the self into the fellowship of God and the world (Hasel, 1983).

Health, illness and healing in the Old Testament

Within the OT, there are indications that sin, sickness and healing are intimately associated. Transgressions of divine law could beget sickness as a punishment. Many Prophets in the OT played a focal part in constructing and propagating the association of sin (disobedience) and sickness (punishment). They frequently admonished their communities against contravening the laws of God or face consequences of disruption to social, economic or individual calamities (2 Samuel 12:14). The OT also presents Yahweh (God) as the healer of his people, who are able to attain healing through faith, obedience and patience in God. However, the suffering within the story of Job also alludes to the fact that not all sickness was due to the committing of sins. An overarching theme within the OT relates to the covenant between Yahweh (God) and his people. It proclaims that observance and fidelity to the commands and laws of God, who created humans (Gen. 1-2) will result in the favours of God to be bestowed (Lev. 26:3-13). However, the transgression and rejection (sin) of the edicts instructed by God will unleash particular punishments that include wasting diseases and plagues, as well social, economic, political and ecological degradation (Lev. 26: 16-39). God’s sovereignty and lordship is

highlighted within the OT through the ability to heal and identification as the ultimate healer or physician, “For I am the Lord, who heals you” (Exod 15:26). No sickness, illness or even death are beyond the capability of God: “I put to death and I bring to life, I have wounded and I will heal” (Deut 32:39). The “wounding” or suffering on an individual could be due to spiritual guidance and enhancement from God and therefore restoration of health may not always be granted. The accent regarding healing and health in physical and other dimensions of life within the Bible is premised on an individual’s theological existential relationship with God. This holistic and wholeness is further exemplified by the deeper dimensions of healing beyond the physical, where often the prayer for physical healing is dovetailed with the confession of sin and spiritual healing (Psalm 41:3-4). In this way scriptural tenets within the OT often did not separate physical and spiritual healing. Hasel (1983) explains healing as not only the mere physical restoration of health but also the incorporation of dimensions of forgiveness and salvation.

New Testament health and healing

Antecedents from the OT provide the foundations for the theological statements regarding individual and community health within the New Testament (NT) (Hill, 2007). The beseeching of help from God helps people to establish a relationship with God, where healing provides a new beginning through comfort and strength. The use of ill health by God may be a means of reprimanding his creation (humans) (Hebrews 12:6) but also a vehicle to augment and provide spiritual elevation to his followers (2 Corinthians 4:17). Ministering to the sick was a major part of Jesus’ vocation, with the proportion of verses in each of the four gospels dealing with healing ranging from 5% in John to 20% in Mark (Wilkinson, 1967). The worldviews of health and illness Christianity are intertwined with one’s relationship with God, sin

and evil; i.e. a psychosomatic unity between the body and soul. Within Christianity, just as seen within public health, the philosophies of health and wellbeing have been diverse across time and denomination where the emphasis of the commitment to healing has varied, according to different places, different times, and within different denominations. Christian health, illness and healing is therefore dependent on who you are and your perspective to particular actions and beliefs. As a result, activities ranging from prayer and anointing or the utilisation of modern medical technology and psychotherapy can all have a theological significance. This intersectionality can be witnessed, as within certain denominations the relevance of the physical healing ministry is cursory and the emphasis is on salvation of the soul, whilst others expect miraculous healing of all disease (Atkinson, 2011: 3). These current polemics regarding the curative function of the Church (physical and metaphysical) arise from a dissonance in theological beliefs and the significance of the earthly healing ministry of Jesus.

The Biblical narrative commences with God creating the perfect good world that included human beings, which were crafted in his own image (Genesis 1:1-31). Sin, death and suffering were imperfections that descended onto Earth following the fall of man from heaven (Romans: 5:12). The concept of individual responsibility for disregarding divine commandments is synonymous to the role of sin in disease (Morgante, 2002). Sin is typically understood as the alienation or estrangement from God or emphasises revolt from a rebellious heart. This rebellion towards God via sin results in individual anguish and illness, yet paradoxically in certain cases this suffering can involve spiritual maturity, perseverance and the reliance of God being enhanced, in such times of vulnerability (Romans 5:3-5).

The Biblical understanding of health also implicates a close association between salvation and healing as salvation (*soteria*) expresses the notions of soundness of physical, mental and spiritual health (Olagunju, 2013). For many adherents of Christianity, illness and suffering can bring "joyful sorrow" when attributed as an element of struggle to God. Such suffering and sickness are comprehended as "avenues of salvation" or partaking and enjoying the elations of Jesus' resurrection and being permitted in the Kingdom of God (Hatfield, 2006). In an era of dominance of modern biomedicine and therapeutics that seeks to end suffering through elimination of illness instantly, the theological concept of suffering is contradictory to health for many and of minute, if any, value.

Jesus' healing ministry

The healing narratives of Jesus described in the synoptic gospels substantiate the will for divine healing (Morgante, 2002). The healing ministry of Jesus proclaimed salvation and new hope in God's kingdom (Atkins, 2011: 14). By bringing life and *shalom* to individuals, the healing miracles helped establish the relationship and experience of the presence of God through Jesus for the nascent Christians (Kydd, 1998: 10). These healings were often public community events and provided visible signs of God's kingdom. The healing periscope's within the gospels provide a pattern and network of symbols that offer Christians a sense of coherence and healing. As well as this it enables them to comprehend this world and hold out to humanity the hope of a future of salvation (Atkinson 2011: 74). The context of salvation encompasses personal, community and ecological health and comes to fulfilment in the NT through Jesus' life and ministry of healing. The Church's ministry of healing forms the story of salvation in Christianity, where the new Age (Messiah in OT) dawned through Jesus.

The direct cause of ill health from sin emanates infrequently within the narratives of Jesus' healing; (Matthew 9:2), (Mark 2:5), (Luke 5:20) & (John 5:14) of the NT. More significant than sin is the role of faith within the NT healing narratives, as it becomes the underwritten presupposition for a lasting cure and health. The degrees of faith appear to denote a spectrum, i.e. ranging from little / weak faith to great / strong faith. However, the restoration of sight to the congenital blind man (John 9:1-41) places neither sin nor faith as causes for cure, but rather the opportunity of Jesus to manifest God's works. Within this pericope, the personal responsibility of the sick person for cure is eliminated and the role of the healer (Jesus) who represents God's will for health comes to the fore. In this way, the healing ministry of Jesus was not something that was done to people but rather it was a revelation of atonement, manifesting to revive the relationship with God (Church of England, 2000: 19-20).

The gospels witness to the pastoral care Jesus had for those of ill health and disability (Matthew 20:34). On occasion, the callousness of the Pharisees regarding those of ill health incensed Jesus, as they were more concerned to breaking the Sabbath working Law rather than the healing of the paralysed man (Mark 2:5). For Jesus, the Sabbath healings emphasised the true meaning of the Law, which was to maintain a state of communion with God through a relationship of health and wholeness (Morgante, 2002). The epicentre of responses to health, illness and healing from a Christian theology worldview revolves around the affirmation of the resurrection of Jesus (Acts 2:31-32, 4:2 and 4:33). All Christian life and ministry initiates from this point. The resurrection demonstrates that Jesus is the Messiah of the OT, who would bring *shalom,* justice for the poor and healing for the sick (Isaiah 53:5). The ministry of Jesus announced the Kingdom of God though the expulsion of demons and healing the sick and also proclaimed the future new restored creation

(Atkinson, 1993). The synoptic gospels narrate the conquest of the powers of evil in this world and over the kingdom of Satan, as Jesus through exorcism and restoring fellowship with God provided healing and salvation by the gift of health. (Moltmann, 1990: 108) describes healings in this world as salvation this side of death, while the raising of the dead to eternal life signifies salvation in the life after death. Within this eschatological framework, the healings of Jesus point frontward to the restoration of the relationship of all things with the divine; “God’s kingdom is creation healed” (Kung, 1977: 231).

Current Christian healing ideology within the UK

The Church from its inception has offered a ministry of care and counsel as part of its life as a worshipping and sacramental community. This provision of care and healing for the diseased, ill and sick emanated from Jesus and continued through the apostles in the post-Pentecost era (2 Cor. 12:12, Acts 28:9 and Acts 19:11). Within the NT, counselling (*paraklesis*) is a broad concept and covers a spectrum of functions, where the definitive aspiration is to become more “fully alive” through Jesus (Atkinson, 2011: 39). This pastoral guidance within the NT seeks to relate faith in Jesus and God, whilst living in the coalface of everyday life. Healing from this practical theological perspective considers people, who are living in this material world and are on a journey of faith towards establishing a divine relationship with God, as well as maintaining a network of earthly relationships. This becoming alive through relationships with God and his creation can be reified by the Christian metaphor of ultimacy that views God as an enabler of communities and giver of life through Jesus and the church. The healing ministry is a revelation of atonement, where those who are healed are made new through liberation of their suffering that results in the strengthening of their relationship with God.

Within congregations the challenge is in allowing God to make each other whole. However, the ministry of healing and utilisation of churches as healthcare providers has been marginalised due to the rise of the secular sphere and domination of secular biomedical dominated healthcare providers, such as the NHS. Caring of the soul and the body has its historical roots in religion, however, the complex and evolving relationships between the Church (religion) and health of the public (science) throughout the ages makes it unfathomable to entangle the precise role of religion within population health improvement in contemporary Western societies (Walton, 2007). Health and healing within many secular medical individuals and institutions focuses on the alleviation of pain and enhancement of the quality of life. Christian ministering to the sick recognises these notions of healing from medical and nursing care but also advocates cure; by prayer, faith (God and Jesus) and the Holy Spirit (Church of England, 2000: 144-145). Individuals may inhabit multiple action guiding worldviews, such as faith (Christianity) and biomedicine and therefore the meanings they may form regarding ill health maybe a synergy of the two. Viktor Frankl's "logotherapy" has been considered as "healing through meaning" that brings instinctual factors and spiritual realities to consciousness (Costello, 2016).

Continuing disability (long term chronic conditions) is a reality for many, with those ministering to such people see many return again and again for prayer and sacramental healing, such as laying on of hands. To be alongside those suffering long-standing morbidity and viewing them as representing the crucified body of Jesus i.e. Christ figure in the midst reifies the notion of a caring Christian community. When the marginalised and vulnerable members of the community or congregation are as important as the best, it instils a better comprehension of limitation and illness and reflects Jesus in the lives of the powerless and those that are suffering

(Atkinson, 2011: 64). The healing or wholeness manifest through Jesus and the church may become apparent through the acceptance of limitations, as we are all limited in one way or another. The gospels are not magic that seek God to do your will but rather a narrative that underscores the limitations of man but also proclaims how these can be transformed to provide theological significance and help elucidate the deepest values of the relationship with God (Church of England, 2000: 144-145).

The healing ministry of the church has been throughout history one of the greatest opportunities to share the visionary, dynamic and prophetic message of the full gospel – hope of healing from physical, mental and spiritual, as well as economic, environmental or political infirmities (Church of England, 2000: xiii). Within this ministry of the Church, its pastoral function is built upon the foundations of a Christian eschatological framework (salvation) that allows individuals to transverse the challenges of the created world concomitantly acting as priests of creation by establishing the kingdom of God (Atkinson, 2011: 85). The healing ministry of Jesus and his disciples was also an attack on Satan's kingdom (Luke 11:14:22), as aetiologically the devil is believed to be at the basis of sickness and sin that results in the severing of the relationship with God. The reconciliation or healing of this relationship could be restored or an individual maybe forgiven if one returned and repented to God through penitence, confession and absolution.

This ministry of healing is often described by theologians as consisting of three streams; the pastoral, sacramental and charismatic. Healing predominantly retains a charismatic character of working through the Holy Spirit, although the sacramental (baptism, Eucharist and anointing) and non-sacramental or pastoral (intercession, friendship and counselling) modalities are common practices within Christianity. The pastoral form developed from the apostolic church over the centuries and became a

way of how Christians attempted to provide care and healing for the sick, from which emerged the early forms of hospital and medical treatment (Church of England, 2000: 90). Pastoral care is traditionally regarded as a primary function of the clergy, although it is also viewed as a duty of all Christians. It is an amalgamation of an interwoven set of activities directed towards individuals within a faith context to foster individual and community wellbeing. Christian counselling can be distinguished from other forms of psychotherapy due to it belonging within a framework of a faith tradition. It also takes a “whole life” or holistic perspective of the individual with the supposition that life is a gift of God. A vital component of counselling is that of “being with” a troubled person can promote healing due to the accompanying individual joining the distressed in time of stress. (Church of England, 2000: 112).

Counselling and psychotherapy in Christian faith organisations seeks to support people with the ability to focus on the psychological, communal and moral interconnectedness of their lives towards to a more balanced sense of identity in Jesus, whilst tackling the challenges of everyday life. This may enable them to not only emancipate their current affliction but also provide understanding to the theological significance of suffering (Hurding, 2000). Many Christians view the cessation of healing miracles with the era of the apostles (dispensationalism), whilst for many the Twentieth Century in Western societies paradoxically witnessed a revival in religious healing coinciding with the achievements of modern secular medicine. The existence of diverse healing ministries (sacramental or charismatic) reify the presence of Christian healing as a pluralistic entity, i.e. no one kind of healing or evaluation of practical and theological implications. (Pattison, 1989: 48-51). A manipulative approach to ministry that seeks miracles and raises expectations among vulnerable people runs contrary to the biblical concept of miracles (Atkins,

2011: 84). These signs of God cannot be manipulated or manufactured, but can be anticipated with prayerful expectation, as prayer is not telling God what to do but opening oneself to the will of God and his grace.

Much of the current and polemic in relation to the ministry of healing of the Church and those in public health or medicine wishing to link their practices with Jesus' earthly healing ministry revolves around theological convictions and action guiding worldviews. The sense of vocation of healthcare staff towards their work is a crucial ingredient to the formation of a healing and caring atmosphere within a hospital or primary care. To many Christian healthcare workers their medical work is viewed by them as healing in the widest sense rather than just clinical repair. Patients taking a similar notion of healing, view as healing being provided by God through the medical professionals within a nurturing environment of the hospital, as they are rehabilitated from illness to fullness of life (Wilson, 1966:75-82). Motivated by elements in their faith and enacting the healing ministry of Jesus, Christian pastors and doctors employ a holistic view of healing through a practical theological approach often combining medical, psychological or spiritual prescriptions. This emphasis on holism was also accented by Lambourne (1963) and Wilson (1966) for whom emulating Jesus' healing are not just individual orientated acts of compassion but a community enhancing worldview that views such acts as parables or disclosures of the judgement and authenticating the Kingdom of God.

If the church's healing ministry is to have any relevance amid the Twenty-First Century medically high tech instant cures, then it needs to bring meaning and hope to people with chronic limiting illness and disability rather than an insignia of stigma, guilt and failure (Church of England, 2000: 127). The personal and community wholeness (shalom) is found in the fellowship with the Holy Trinity. The pursuit of

health thorough political, social and secular medicine, as well as prayer allows the ability to tell God our needs, hopes and fears and “cast all your anxiety on him because he cares for you” (1 Pet. 5:7). Healing as merely the restoration of function places value on dysfunction and disability rather than on the individual and their identify formation or its theological significance. Jesus’ healing ministry is an ongoing proclamation of God’s miraculous powers and not an episodic response to sickness (Atkinson, 1993). It is a sacrament of God’s grace led by the worldview of a restored creation within which the healing and salvation of individuals, as well as illness and suffering may be necessary for wholes to be attained.

CASE STUDIES

Outline of Case Study 1 – Depression

This case study section on depression will conduct a critical conversation by examining the historic and contemporary interactions with society to identify opportunities and obstacles for collaborative healing. Depression has been a social problem throughout history that has had been shaped by existential social, cultural and political frameworks. Psychological change takes time and therefore individuals require secular or religious frameworks that can empower and reduce stigma.

Historical narrative of depression

Melancholia, depression and their cognate terms have throughout human history had variegated explanatory schemas regarding dejected and elated (manic) states, emotions, moods and symptoms. The experience of being melancholic or depressed throughout history referred to an assemble of signs and symptoms that either in isolation or in totality comprised of a disease, an ephemeral mood or emotion that was troublesome but not pathological or may denote a temperament / character type. It is for these reasons that the various conditions and wide spectrum of states of melancholy and depression transcend the boundaries of just a mere disease (Jackson, 1986: 3) and reside in the paradigm of mental disorders (Helen, 2011). McGilchrist (2017:2) a psychiatrist and subject to depression himself describes depression,

> ‘as not like anything on earth. It is not the same as being sad but like an existential terror that seeps into your body, brain and bones and everything that surrounds you.’

Mental illness is paradoxically one of the most solitary states of an individual, yet it is also the most socially visible to those who observe ifs effects. The epithet of insanity,

madness or mental illness on individuals whose speech, mood and behaviours reside outside their communal frameworks is as old as humankind (Porter, 2002: 10). Aetiologies of mental disorders in ancient times included demonic possessions, and witchcraft (Porter, 2002: 12). Healing was usually assigned to shamanist that resorted to supernatural therapy, such as divination or sacrifices, as well as rationalistic herbal prescriptions.

The rationalisation of humans by Greek philosophies attempted to define man as a rational animal, within a system of nature, where reason alone could rescue humans from the irrational; mind over matter (Porter, 2002: 35). By the exaltation of order and logic and the replacement of magic by medicine, mental illness was plucked from the sphere of the celestial to the terrestrial. Hippocrates (d. 377), a proponent of the natural medical model of mental illness, attempted to translate the inner psychological conflicts and dissonance of individuals into physiological terms through the theory of humoralism. Humoral medicine explained health and illness through a comprehensive explanatory scheme of humours consisting of black bile, blood, phlegm and yellow bile. Healthiness within individuals was dependent on the steady state or equilibrium of the humours, whilst sickness resulted from excesses of these determinants. Excess black bile was considered to be the central element in the pathogenesis of melancholia (Jackson, 1986: 7).

Historiographies of individuals and communities that have experienced or witnessed rejection by the majority due to ostensible mental illness or disorder have endured a variety of actions and reactions under different historical, cultural and ideological climates (Rosen, 1968: ix). Historical analyses of past social structures and community frameworks (Jackson, 1986; Porter, 2002) have illuminated several themes that are pertinent to developing a better contemporary psycho -social

perspective of those people considered to be suffering from a mental illness (Read, 2004:9):

> 1) Therapy or treatments are used for those considered with mental disorders, to suppress behaviours, thoughts and feelings objectionable to those with the authority to establish social norms
>
> 2) Therapy or treatments are often unhelpful, especially at addressing the aetiology of the mental illness
>
> 3) The socio-political functions are frequently camouflaged by the specialists of the day, with the diagnosis and prognosis often associated with individualistic defects

The manifestations of mental illnesses within individuals are reified through their relationships with other people. It is for this reason that mental disorders are immensely shaped by existential social, political and cultural frameworks (Rosen, 1968: ix). Mental disorders tend to alienate their victims from other members of society due to their dissonance of convention in action, thought and emotion (Macdonald, 1981: 1). The history of mental illness has not just been a narrative of disease but one of relationships of power, enacted through individualistic, institutional and ideological entities in society (Bynum et al, 1985: 2).

Depression has throughout history been a cultural artefact that has been formulated through varying expressions and emotions in different societies, i.e. it has a historical ontology. Therefore, what depression is today reflects current sociological or aetiological understanding (Helen, 2011), which is bound to change in the future to reflect existential circumstances. Modern psychiatry's dominant worldview for ameliorating depression is adopting the biomedical model, resulting in the reliance

and hegemony of psycho-pharmacological treatments. The perils of the contemporary therapeutic paradigm of depression is to think of depression akin to other somatic disorders as endogenous entities that can be identified and manipulated through psychotropic drugs instead of it being a psycho-social experience. Instead, its epistemic foundations lie in the realms of epidemiology, nosology and pharmacology (Helen, 2011).

Sociological narrative of depression

Sociology allows the interrogation and understanding of the nexus between social and personal opportunities and challenges in life. The perennial and ubiquitous nature of mental disorders, as well as its chronicity has made the mentally ill a familiar but ignored and neglected part of the social landscape within historical and contemporary society. This invisibility is a manifestation of the stigma faced by the mentally ill, where these individuals or groups are extruded by the community and distanced from the main social structures of ordinary citizens, i.e. are often residents of 'no society'. Mental wellbeing is a vital component of life, especially in the growth, development and resilience of the physical and psychological health of the public (FPH and MHF, 2016:9). Poor mental health affects not only their psycho-somatic health but also hinders their ability to socialisation, a prerequisite of the modern individual due to the essentialist elements of individualist societies that require values such as self-value to succeed (Ehrenberg, 2010: xiii). The mental wellbeing of individuals is a challenge to everyone in society (Pattison, 1986), with the World health Organisation (WHO) estimating that mental disorders are ubiquitous, affecting a quarter of people (one in four people) during their lifetime (WHO, 2001: x). This ubiquitous phenomenon that corresponds to personal and social disruption described as mental illness in contemporary times is not a new or recent occurrence

(Pattison, 1989: 103) and has run like a watermark throughout the history of mankind. Every society has recognised certain extreme forms of aberrant behaviour as mental derangement, where this social judgement has been dependent on contextual socially tolerable limits (Rosen, 1968: 101).

Throughout history, depression has been a social problem and therefore the hegemony of its current medicalisation aetiology of depression may fail to empower suffers to comprehend the social elements of their depression (Furman and Bender, 2003). One of the central notions within mental disorders, such as depression is what the sufferer denotes as the existential conception or meaning of their condition. Humans are meaning seeking creatures and therefore feelings of nihilism and lack of coherence lead to instability as they reside in the midst of the lonely desert of this chaotic social landscape (Camus, 1955: Preface). According to (Mirowsky and Ross 1986) alienation, authoritarianism and inequity are three key themes in comprehending the outward impartial reality of society, as well as understanding the inward reality of individualistic anguish. For Karl Marx, a society's mode of production and economic structures greatly impacted and determined social relationships. The rise of capitalism during the nascent industrial age lead to the alienation of individuals from their labour, as work was for the sake of production and not an outlet for self-expression (Ollman, 1977: 153-156)). Marx's hypothesis on alienation are relevant to organisations today and remain pertinent to human resource management, if they are to understand the potential of detrimental health outcomes and wellbeing from the contemporary dominant capitalist mode of production (Shantz et al, 2014). Community surveys have reported that depression decreases as one's internal sense of control increases, as it encourages a person to actively tackle problems and undesirable consequences. Perceptions of support and

control are alternative ways of dealing with pressure and therefore operate antagonistically in reducing depressive effects by diminishing the influence of factors outside the control individuals (Mirowsky and Ross 1989).

Public Health narrative of depression

Mental health and psychological maladies are not limited by age and can affect anyone, causing extensive strain on the lives of individual sufferers but also their carer's, families and communities. In terms of disease burden, mental illnesses within England account for around 1/5 (21%) of the total morbidity (Makurah, 2018). Poor mental health has a devastating impact on life expectancy, such that those suffering with poor mental health die fifteen (women) to twenty (men) years earlier compared to the general population (Thornicroft, 2013). This excess mortality or inequality has been attributed to a number of factors that include socioeconomic factors, provision and access to healthcare and clinical risk management (Druss et al., 2011).

Depression during current times is firmly linked to the concept of 'disorders of affect or mood' and refers to a symptom - pathological sadness, a syndrome - a cluster of signs and symptoms and a disease - causal pathophysiological explanation (Berrios and Markova, 2017: 46-48). This broad and wide-ranging diagnosis criteria risks overdiagnosis and overtreatment of previously undetected people, as the increased essentialisation and individualisation of depression has focussed the attention away from the social and political contexts of mental illness (Vilhelmsson, 2014).

Depressive disorders constitute a major disease burden with England and is deemed a major current public health issue. These disorders have been tackled predominantly through the specialities of psychology and psychiatry, with a focus on primary and secondary therapy rather than preventative upstream measures.

(McLaughlin, 2011). The mind and its sciences, especially psychiatry occupies an ambivalent status in modern medicine due to their indecisive nature and lack of internal ideological consensus (Hayward, 2011: 524). Prevalence of lifetime major depressive disorders (MDD) within the United States and Western Europe is thought to be around 13.3 – 17.1% (Carta et al, 1995). Depression is regarded not only as progressive but highly recurrent, i.e. even if minor symptoms are left untreated, the symptoms will become more severe (Helen, 2011). Depressive disorders can also exist alongside other chronic conditions, such as diabetes and cancer and therefore influence cumulatively the outcome of these comorbid illnesses (Cassano and Fava, 2002). Depression is a leading cause of disability in males and females and is recognised as one of the leading contributors to the global burden of disease (WHO, 2001). Despite the recognised effectiveness of treatments for depression, a great proportion of sufferers do not receive treatment due to the social stigma associated with mental disorders, as well as the under recognition of depression by clinicians (Lecrubier, 2001). In terms of laypeople's understanding of mental disorders, (Haslam, 2005) outlines a socio-cognitive model that revolves around four public and cultural dimensions; moralising, pathologising, medicalising and psychologising. These dimensions are not exhaustive. The framework has the potential to highlight and conceptualise the social cognitive cultural variations of mental disorders and illuminate lay concepts of psychiatric stigma. It could also provide clarification around understanding shifts in the public's explanatory framework of abnormality (deviance) and health seeking modalities for psychological illness. WHO (2012) report effective community approaches to prevent depression. These approaches are based on enhancing the protective factors (asset-based approaches) and reducing the associated psychosocial risks (WHO, 2012). Interventions need to target the individual, community and structural determinants through interdisciplinary

collaborations (pubic heath, psychiatry, religious organisations), where methodological approaches are bridged to foster effective partnerships to improve population health (McLaughlin, 2011).

Critiquing the moralising (sin) and medicalised (disease) models of depression, Scrutton (2015) indicates that both these models are problematic and responses to depression need to be sensitive to individuals and their contexts. The moralising of depression to sin is likely to exacerbate psychological problems and increase alienation, as perceptions of guilt and self-blame are a common characteristic in depression. Moralising models inherently place the cause of the depression to the individual and consequently fail to recognise the social causes of depression (societal sin) and the church's role in combating social injustices. Evaluation of medicalised models to depression reveals an essentialism towards mental illnesses within lay people (not within professionals) who often conceive mental illness as having an ontological reality or existence, as opposed to it being a socially and culturally variable construct. The essentialism or separation between the person and the disease may diminish the stigma of blame and guilt of moralising sin induced (free choice) depression. However, this medicalisation can ebb the chances of recovery due to the inducement of prognostic pessimism and repudiation of other forms of therapy; cognitive or spiritual.

Theological narrative of depression

Within the Old Testament Book of Deuteronomy, Moses reflecting the prevailing world view of Ancient Mesopotamia (2000 B.C.) describes the divine retributive aetiology of mental ill health. The curses for disobedience in Deuteronomy outline that mental cognitive dysfunction may result from adverse life experiences, which could have been invoked due to divine punishment for contravening the code of

social norms proclaimed in the Commandments (Deuteronomy 28: 15-30). Within the New Testament, individuals (demon possessed) often receiving healing from Jesus were those who in contemporary society would be described as mentally ill. As every society views certain types of deviant conduct as some type of insanity, throughout history there has been no monolithic understanding or response to mental illness. However, since time immemorial, mentally ill persons have been invisible, stigmatised and socially excluded due to occupying a negative sanctioned role in society (Pattison, 1986). Early Christianity certainly propagated a parochial super naturalist aetiology to mental disorders (Pattison, 1989 :105) through lexicon, such as evil spirits / demons / possession to mental disorder, illustrated through the isolated Gerasene demoniac amongst the tombs in the New Testament (Mark 5: 1-20). However, early Christians hesitated to attribute the cause of all hardships or illness (physical and mental) due to the sufferer's sin as Jesus did not always attribute illness to sin (John 9: 2-3). Within contemporary Christianity many mainline denominations sanction scientific, medical or psychological conceptions of mental illnesses, while others subscribe to exclusively religious conceptualisation of psychopathology (Webb, 2012). Lay theologies of mental illness reflect this denominational diversity of beliefs that have been assessed through research within congregational communities.

Gray (2001) reported survey results from a theologically conservative Anglican rural congregation consisting of a predominantly white middle-class congregation. They had less negative views towards those suffering from psychological disorders in relation to the UK population. This finding was contrary to the initial hypothesis (congregation may have generally negative views due to the association of mental ill health with sin and demonic possession), augmenting the plurality views that may

exist within church congregations. Research in Australia (Hartog and Gow, 2005) reported nearly 40% (2 in 5) of Protestants across a wide range of denominations thought that major depression and schizophrenia were caused by supernatural (demons) influence. A similar percentage also stated that they did not believe that demonic influence was an aetiological factor of depression or schizophrenia.

Pentecostals in the United States responded to a survey that examined aetiologies and therapies of depression. A list of thirty-two causes were reported, where demonic oppression / possession ranked fourth, whilst prayer, confession and Bible reading were deemed as the most efficacious treatments. (Trice and Bjork (2006). Findings from an online survey that assessed attitudes and responses mentally ill Christians encountered when seeking counsel from the Church stated that up to 30% experienced a negative experience, whilst the rest related the acceptance of Church and a positive response (Stanford, 2007). The negative reactions comprised of mental illness being associated with demonic influence and personal sin, as well as abandonment by the church. These disapproving interpretations demonstrated a gender bias, with women more likely to endure such dismissal by the church.

In general, lay theology research has highlighted that many (not all) Christian congregants that seek counsel from the Church for their mental disorders may have interactions that are counterproductive to their conditions, i.e. exacerbate guilt. Mental disorders, such as depression are often interpreted as exhibiting a lack of belief in God or punishment for individualistic sin. Therefore, many sufferers of mental ill health find Stepford Christianity (psychological distress is not acceptable and humans have a causal *quid pro quo* relationship with God) proponents as unsupportive and exacerbating their distress. The story of Job refutes the Stepford hypothesis. Job's suffering, misfortune and internal struggle provides individuals the

meaning to exist in this world with a dynamic connection with an omnipresent God, amidst the trials of life (Webb, 2012). A supportive religious interaction can not only play a vital role in recovery from conditions such as depression but may also provide resilience or even prevent further episodes (White et al, 2003).

Biblical scriptures contain many narratives that feature the suffering and psychological distress experienced by many prophets Job, Joseph and Jesus. Within the Book of Hebrews (5:7) Jesus is said to have, “offered up prayers and petitions with fervent cries and tears to the one who could save him from death,” about his imminent capture and death. Even though many Christians regard depression as a portrayal of a lack of faith, paradoxically many view it as an opportunity for spiritual health or a potentially transformative experience (Scrutton, 2015a).

In the context of religious depression, feelings of abandonment by God can become a moment of crisis for some individuals, whilst for others it is viewed within a positive framework of meaning and purpose. The positive framework experience is perceived as an opportunity for enhancing one’s spiritual health. As the aetiology of this depression is supernatural and attributed to God, the purpose of this suffering is for it to become a means of achieving a closer reliance or relationship with God. Following the archetypal of the *Dark Night of the Soul* narrative, proponents of this enhancing spiritual theology frequently view depression and other mental illnesses as spiritually pedagogical and purgative. A relatively recent exemplar of religious depression theology was revealed in the posthumous publication of Mother Teresa of Calcutta (d.1997) letters in “*Come Be My Light”* to her spiritual advisors that give testimony to her internal turmoil, which, was in contradiction to her external joyful demeanour. Throughout her extremely long darkness Mother Teresa along with her spiritual advisors tried to make sense and attribute meaning to her experiences of

abandonment (salutary madness) within a theological prism of spiritual maturation (Durà-Vilà and Dein, 2009).

One of the risks of a spiritual health theology is that the suffering of the depressed individual maybe romanticised or idealised. This may give it a false sense of reality or represent it as a quasi-good, whilst neglecting the anxiety and turmoil that is endured by the individual and those close to them. Dark night of the soul narratives also may also potentially act as a therapeutic barrier, as it may diminish the person's motivation to recover and to remain ill, so that the spiritual purification or enhancement may continue and remain elite in the eyes of God. Psychological distress and depression have also been described by (Scrutton, 2015a) as a potentially transformative theological experience, with less emphasis on the saving power of the suffering but instead emphasising the potential of positive change. It can include the idea of the 'wounded healer' (Scrutton, 2015b), where this notion implies that the wounded person has the ability to health others due to their experiences. (Stringer, 2002: 112) writes that depression is an alarm or warning sign, (just like canaries in a coalmine) analogous to physical pain, alerting the individual that something is not right wrong and it's time to reflect. The idea of an alarm or anxiety through physical manifestation does not preclude that depression may also have a physiological cause and thus psychotropic treatments provide relief and day to day functionality. An objection to this transformative theology is the retrospective autobiographical nature of the accounts reduces their validity, i.e. a romantic or spiritually elitist take on depression after the event. (Karp, 2002: 148) talks about how the recognition that depression is not ephemeral but has a continual presence enabled him to resort from a fire fighting problem-solving approach to a caring transformational suffering that does not offer the illusion of a problem free life.

Current challenges of the church and depression

Many Christian congregations have responded to the challenge of mental illness in their midst, however, the response has been *ad hoc,* with no national overall policy of the church's attitude to the mentally ill (Pattison, 1986). Research evidence from several studies alludes that religiosity maybe protective for depressive symptoms (Smith et al 2003). Many religious narratives demonstrate how the perseverance of theological convictions and sense of purpose allow individuals / communities undergoing social and economic turmoil to be resilient and not have an overall sense of helplessness or despair. The existence of a compassionate God amid any depressive struggle may ameliorate the anxiety associated with the depressive episode and offset hopelessness (Murphy & Fitchett, 2009).

A frequently disregarded component of pastoral theology is the degree to which individuals within the congregation or the wider community may be subject to mental illness or suffering from undetected depressive disorders. As mentioned before, depression in many denominations may be labelled as a spiritual malady. The perception of God by individuals suffering from depression may be different than those within the congregation without the condition. Sorenson (2013) encourages church pastors to give consideration of the gaps in understanding that people with depressive disorders may infer from emotionally charged beliefs and ideas of God, sin and suffering. Establishing, meaning, and social coherence are indispensable to understand the emotional culture of the church and thus a person with depression perhaps does not form the same emotional connection to the Holy Spirit as others. It is possible that people with depression may succumb to the realisation of the ephemeral nature of life and consider quitting it altogether. Homiletic compositions should consider providing extra interpretation for depressed congregants, so as not

to reinforce neurotic tendencies. As oppose to a reliance on emotions of love and grace, religious connectedness could be engendered through rituals and theological framing. The use of the pulpit by clerical staff in the church maybe a means through which undetected depression suffers can be brought to health by the religious reframing and normalising of depression.

Since the early 19th Century the notion of divine passibility, i.e. God as a fellow sufferer gained prominence and countered previous concepts of impassible or emotionless God (Scrutton, 2013). (Webb, 2012) suggests the passibilist theology on mental illness as offsetting the oft alienation and God-abandonment often associated with Christian psychiatry. Although not all may be able to resonate with a suffering God and may have difficulty with the metaphysics associated with passibilism, for others it may be comforting.

(Webb, 2012) suggests three reformulations and categorisations of theological conceptualisations of mental illness. The first reformulation is termed as heroism in frailty. Within this category, unlike the rejection of psychological distress in some forms of Christianity, heroism when facing distress is advocated, akin to the trepidation of Moses before the epic exodus (Exodus 4:13). Although this maybe messy and demands enormous physical and psychological energy, it allows those suffering from depression to traverse the daily battles of even mundane tasks that can seem daunting due to the confusing, sorrowful and frightening perspective of the depressed person. These individuals still try to embrace life and try to find freedom from their hardships. The paradox of manifesting power in weakness can be witnessed in the apostle Paul, who admits his own inability to find relief in personal infirmity, he receives assurance from God (2 Cor. 12:9-10), i.e. God's strength is most powerful in times of human weakness. Related to this heroism is another

reformulation called; freedom in finitude. Again, this paradox highlights that there is hope amidst the journey of life that may include depression, anxiety and suffering. The journey of psychological change over time may develop traits such as hope and perseverance, as the promise of ‘quick fixes’ for sufferers of mental illness can be detrimental. Although miraculous changes of psychological health can occur through divine intervention, however, the incremental change ensures that the person is empowered and participating in the change, rather than a spectator.

A final reformulation of mental illness is themed as, “the stranger in our midst: Christ as Immanuel”. Often misinterpreted and mistreated, those suffering from mental illness are frequently treated as pariahs and experience estrangement within their communities, yet God is aware of all. The life of Jesus is a narrative of estrangement. To discredit Jesus, he was give the sobriquets of “raving mad” and “demon possessed” (John 10:20). It seems these monikers have not much changed over the millennia in terms of stigmatising those with mental illness. Individuals with depressive disorders can take solace from the biblical statement “God with us” (Matthew 1:23), i.e. during their feelings of estrangement and abandonment, paradoxically, they are not alone, as Jesus is Immanuel.

Bennett and Hale (2009: 79-87) describe several steps that an effective preventative (primary, secondary and tertiary) congregational program on depression should consider. These are:

1) Devise a health education program that allows people to recognise the signs and symptoms of depression
2) Provide hope and encourage to seek professional help through reducing stigma
3) Inform individuals regarding biological and psychological treatment options

4) Inform the congregation on guidance and support available regarding support groups and other services
5) Embed steps 1-4 into regular congregational programs and publications

The nature of the challenge for churches regarding mental illness sufferers are numerous and complex. The role is not just the advocating and recognition of stigmatised individuals but revolves around adherence and certain reformulations to the theological Christian traditions of Jesus' ministry of caring and healing for the sick and the concern for justice and social order. Community churches could act as 'anchor institutions' where they can work alongside state provisions and coordinate locally to tackle challenges that focus on the needs of particular groups and communities, such as suitable housing, physical and emotional support and useful employment. A socio-politically appropriate response is required by the church that incorporates not just that reconciliation and healing of individuals but also focuses on the societal prevention of mental ill health. Given that it is difficult for the mentally ill to make demands upon wider society or achieve a political voice (political impotence), the church could be that voice that ensures provision and services for the mentally ill are given sufficient resources and priority. The challenge is to highlight the concerns endured by those suffering from mental illness but also being cognisant of the extra demands that may be propelled upon them by the diminishing welfare state.

Church based public mental health promotion conducted alongside or in collaboration with localised public health teams can have the potential to reach not only those in the church but also those in the wider community, as well as reducing health disparities (Campbell et al, 2007). Clergy and other church staff with the appropriate training (mental health first aid) can operate as knowledge brokers for

those with mental illness providing theological explanations but also being able to sign post to specialised services, thus complementing both natural and supernatural aetiologies of mental illness. It is also incumbent for public health as a discipline to move out of its dominant biomedical illness modus operandi to a more bio-psycho-social model considering health improvement through psychological and interpersonal factors. Church engagement and dialogue with public health is tantamount as is the engagement of public health with faith based and community organisations. In order to facilitate community and place appropriate development of interventions for people with mental illness, an asset based approach (FPH and MHF, 2016) could facilitate collaboration between the church, public health and the local population. This collaborative healing between pastors, public health and psychiatrists has the potential to reconstruct a physically and psychologically broken person by bringing them from seclusion to freedom.

Outline of Case study 2 – Acquired Immune Deficiency Syndrome (AIDS)

This second case study will be on AIDs and has a much shorter epidemiological and social history than depression. However, many of the same factors have emerged in responding to this sexual disease, such as the creation of xenophobic segments of the population, stigmatisation and ostracism. Transforming theological thought is required to grapple with the complexities of human sexuality. The narratives will discuss AIDs from several different perspectives, with an emphasis on reflection and context on the Christian ethics of sexuality rather than distinguishing responses between different churches and denominations to the AIDs pandemic. As such, references to "the church" refers to Christians of all persuasions and the church as an institution. There needs to be a shift in the essentialisation and reification on positions in order to develop practical solutions both within public health and Christian attitudes to AIDs, which revolve around a healing community.

Historical narrative of AIDs

Sex and sexuality are central to human existence and relationships; however, both are often confined to the 'context of the one' the individual self rather than in the 'context of the many' (Woodhead, 1997:99). Often viewed as a protean force, human sexuality has been undergoing perpetual vicissitudes throughout history due to its complex, variegated and often ambivalent relationships with the social, cultural and political elements of society. Sexuality is therefore both a historic and personal experience, as the contending forces of power, choice and judgement are coloured with historical heritages rooted in a melange of religious, scientific and sexological arguments, leaving little room for essentialism or absolutism (Weeks, 1985: 4-5). Within Britain, the struggle between conservative and liberal traditions regarding sexuality came to the fore during the 1960s, with epithets for this decade including;

“the sexual revolution”, “sexual freedom” or ‘the rise of permissiveness’. These terms however, have been strewn together as descriptors of the changes that have occurred – but their overall meaning is obscure; as it is unclear who the freedom was from, by what means and at whose expense? Since the 1960s, there have been unequivocal transformations of the historical understanding of sexuality. From a seldom presence in comprehending social history, sexuality has become a crucial and prominent element for the understanding of the social dynamics of society (Weeks, 1993: 18).

Indications of sexually transmitted or venereal disease exists from antiquarian sources, with evidence from Mesopotamian clay tablets “cradle of civilisation” and Egyptian papyri depicting paintings of these maladies (Gruber et al, 2015). Even though these diseases have been omnipresent in society, historians have been reluctant to investigate historical attitudes of sex and sexual behaviour (Bullough, 1972). The discipline of sexology (study of human sexuality) has in recently times flourished and is now characterised by rich methodological and interpretive diversity. Sexuality was deployed as a prism through which social, cultural and political preconceptions of gender roles and sexual attitudes were being investigated (Thomas, 1959), as according to French historian Claude Quetel (b.1939), nothing is more revealing of a society than the history of its ‘social’ diseases (Quetel, 1990: 2). The socio-political upheavals of the 1950s and 1960s; civil rights campaign and the apparent rise of permissiveness during the 1960s gave legitimacy to the study of sexuality through anthropological and sociological exploration (Davis, 2011: 503). The advent of Acquired Immunodeficiency Syndrome (AIDs) epidemic since the 1980s has led to a resurgence of interest in the historical relationship of sexual disease to society (Berridge, 1993: 1).

Historical models of dealing with sexual diseases maybe a window that may provide understanding of the current social and political aetiologies of AIDs. The unforeseen materialisation of AIDs in Britain during the 1980s posed challenges for individuals, institutions and ideologies, due to the rarity of dealing with global epidemics in modern times (Ferlie, 1993: 203). The role of history can be to provide 'lessons of history' for policy formation and elucidate explanatory models for people living them. The lesson from history within the UK to AIDs from syphilis emphasised a voluntarist, non-punitive and confidential response (Porter, 1986). Taking lessons from early Twentieth Century syphilis epidemic (Brandt, 1988) advises the consideration of four lessons; fear, education, compulsory measures & effective treatments, to discern whether interventions will have a positive effect regarding future trajectory of the AIDs epidemic. There are however, no simple truths in history and thus the response to AIDs will be required to be taken in its social milieu, as was the reaction to early Twentieth Century syphilis. Given that AIDs is now approaching forty, it now has its own history and is less reliant on historical pandemic discourse. Current responses need to answer existential and relativist questions. Although, historical precedents can provide analogues as a means of devising contemporary policy. The fear of AIDS emanated from irrational feelings about sexuality, chastity and causal transmission of AIDs creating several xenophobic segments of the population that were perceived to have a greater risk of the disease and therefore experienced stigmatisation and ostracism.

The AIDs epidemic is framed and burdened by numerous histories (Fee and Fox, 1988: 4). This includes past epidemics of sexually transmitted diseases (STDs) and the social, political and cultural responses to the regulation of sexuality (Weeks, 1993:17). As with the syphilis epidemic of the early 20th Century in the US and UK,

AIDs has engendered powerful social conflicts, gender inequalities and highlighted the social dynamics of sexuality, as well as the equivocal function of governmental public health policy the attempts to protect and promote healthy policy through individual and population level interventions. In this way, AIDs has reflected many similar tenets of syphilitic history, such as the fear of contagion, sin, causal transmission, stigmatisation of victims and tension of civil and population liberties (Brandt, 1988). AIDs appeared in the early 1980s amid a cacophony of debate around sexuality, following two decades of rapid social and cultural changes regarding new discourses of sexuality. The shift of social mores in the liberalisation of views concerning matrimony and childbirth were perceived by many a putative secularisation from absolutist Christian standards towards more pragmatic individualistic belief systems or permissiveness. However, these shifts were accompanied by much uncertainty and moral confusion. The legal changes of the Wolfenden Report 1967 (legalisation of homosexuality) were premised around the supposition that legal absolutism through the state and the church was an inappropriate social mechanism to regulate sexuality. The law's role was to uphold public order and decency rather than proscribe certain values or maxims. So rather than a sexual revolution during the 1960s, it can be viewed as a decade of sexual evolution or legal revolution of sexuality. As a result, the AIDs epidemic raised difficult questions between private sexual behaviour and public policy (Weeks, 1993: 23).

Sociological narrative of AIDs

Human sexuality and sexual norms are experiences that emerge through social environments and are socially constructed. As a result, sexual meanings can be dramatically transformed across cultures, groups and individuals. The 1960s/70s

saw much reorganisation of these meanings and sexual identities in the Western world, as major demographic, family, media and economic changes manifested. However, sexualities have been transforming throughout history, although these changes are never easy, due to the individuals, institutions and ideologies that are implicated, which give them a sense of semi permanence (Plummer, 1988: 42-44).

The social construction of sexual relations is the product of multiple historical and social renovations of populations by secular and religious interventions, moral entrepreneurs and legislators. It is therefore not surprising that sex and sexuality are a generative basis of “moral panic”, as they raise queries concerning self, power, politics, judgement and social boundaries (Weeks, 1985:45). The regulation and control of sexuality has historically been enacted in the Christian West through a number approaches; absolutist, liberal and libertarian (Ellis, 1980). The absolutist position resides on a clear morality that revolves around strong familial and monogamous principles that influence aspects of life in private and in public. In contrast, the liberalist position focuses on the distinctions concerning morals and the law delineated by the responsibility of legalists to police public order and decency rather than regulate individualistic behaviour. The central tenet of the libertarian approach is that repressing sexual expression within society is parallel to societal subjugation. However, such libertarianism can impose an authoritarian view that sexual expression is not only pleasurable but necessary. It is only through the emancipation from absolutist, dogmatic or utopian ideals but the acceptance of diversity, antagonisms and contradictions; a “radical pluralism” it becomes evident that sexuality is not an immanent truth.

The shifting of sexual mores since the 1960s and repose of prevalent sexualities over the following decades was of great significance to the AIDs crisis. Since its

emergence AIDs has since been a symbol of vicissitudes in social, political and religious moral boundaries. These ruptures in ‘normal moral behaviours’ where often used as yardsticks to measure the supposed decline of moral standards. The action guiding views of religious mores were receding within UK society. The changes in legislation on homosexuality, abortion and divorce during the 1960s were repudiated by many moral conservatives and the churches, developing a storm of moral absolutism and social purity. AIDs was and is still described by many, ‘as the wrath of God’ by many moral entrepreneurs; including those from the Church. However, there are many theological and moral dilemmas when attempting to answer the question: Is AIDs God’s punishment of same gender relations? For example, not all homosexuals become afflicted with the disease and many others who have never engaged in homosexual behaviour still catch the disease (Baggett, 1994). A social dichotomy of sufferers exists, such that, there are the innocent victims and those who are culpable. Individuals from the former category include, those undergoing blood transfusions (haemophiliacs), females infected by bisexual men and children, whilst the latter category comprises of needle injecting drug users, homosexual men and promiscuous individuals. NatCen’s British Social Attitudes survey reported in 1987, during the apex of the AIDs emergency, two thirds (64%) of respondents stated that homosexual liaisons are immoral, while the latest survey in 2016 reported approximately 1 in 5 (19%) agreeing that these relationships are wrong. This shift over the last thirty years has been especially pronounced among those of a Christian faith (NatCen, 2017). Current attitudes to sexuality within the UK can be described as an ‘unfinished revolution’ where there has been fundamental changes in the pattern of relationships, however, as the effects across society have been asymmetrical , this has led to polemics and residues of fear and anxiety (Weeks, 1988:15).

AIDs from its outset affected marginal and marginalised people, such as homosexuals and drug users. Therefore, moral panics emerged as the confusion and ambiguity of the boundaries between what is acceptable and unacceptable behaviour was blurred and required redefining. It is evident that the regulation of sexuality cannot be understood through a monocausal narrative but rather the interaction of disparate and complex forces; burdened by multiple histories (Weeks, 1993: 32). As per classical elements of moral panics; there was the classical stereotyping of the main actors, who were perceived as pariahs. Popular societal discourse was fuelled through the media (especially tabloid) shaping the epidemic as the 'gay plague'. The portrayal of the disease in the mass media were being used to articulate modern theories of sexuality and the continuing ideological battles between proponents of a conservative moral order (heterosexuality) and a radical alliance of libertarians, gay and feminist movements (Altman, 1986: 21). Moral panic theory, however, does not explain why these social flurries occur but rather alerts attention to recurring phenomena and themes. Consequently, the first major public stage of the AIDs epidemic can be described using the epithet of 'moral panic'. This ostracisation of individuals was not universal, as there were also instances of altruism and self-sacrifice towards those suffering from with AIDs. In essence there were two simultaneous epidemics; a parallel plague of panic dovetailing this 'gay plague'. This perception of the disease determined the responses of both the communities affected and the governments trying to abate and comprehend this mysterious illness (Weeks, 1993: 26). In terms of AIDs policy development by the UK government, it has itself gone through at least three stages. The early period (1981-86) was that of an epidemic disease, characterised by minimal official action and inertia due to the shell shock of the emergency. This initial inertia followed by a crisis or war period (1986-87) that saw action from all sectors of society – public,

private and voluntary, as an unparalleled national health education programme was launched. Since 1987, AIDS policy has focussed on the model of chronicity and normalisation (Fox, 1990) due to the elucidation of risks and aetiologies, as well improved therapies that have improved survival rates post infection. The longevity of the AIDs pandemic has been problematic for the moral panic theory, as it is a panic that refuses to cease and resembles more of a ‘movement’ than a temporary panic. An explanation for this continuity maybe since AIDs commentary draws on several concerns at multiple levels. This multiplicity of concerns is opposed to typical ‘panics’ that appear and disappear and therefore due to its persistent presence, the AIDs epidemic can be described as a condenser of political and social sexual disquiets (Watney, 1988:58).

AIDs offers a vivid example of how multiple contested explanations of health and illness are shaped by historic and social constructions or paradigms of disease (Fee and Krieger, 1993). The initial explanations of AIDs as a “gay plague” were due to the emergence of cases in homosexual men. This classification was challenged by the appearance of AIDs within blood transfusion recipients and haemophiliacs. The identification of Human Immunodeficiency Virus (HIV) – the causative agent in 1983 led to the materialisation of the second paradigm, where AIDs was characterised as an infectious disease. This identification also engendered an existence of pluralistic ideas of proximate and distal causes of the syndrome, which ranged from “magical contagion” to moral convictions. The biomedical model focused not on risk groups but risk behaviours, advocating individually orientated methods of prevention, such as condoms or needle exchange for drug users. The biomedical model is typically reductionist and ahistorical in nature and premised on the ideology of individualism. It also has a notion of human behaviour as abstracted and emancipated from the

social conditions / determinants and communities that shape individuals lives (Fee and Krieger, 1993).

Adoption of the infectious disease paradigm failed to consider many of the social realities of discrimination of AIDs sufferers and fuelled the ethical problem of identifying individuals as HIV positive, especially in the formative years of the epidemic, yet no therapy was available. The normalisation of AIDs manifested as the management of AIDs shifted from an acute illness to a chronic disease (Fee and Fox, 1989) to be managed over the long term. Although each paradigm of understanding captured crucial elements regarding AIDs, neither provided adequate efficacy for reducing the infection rates in high incidence countries within Africa. A third change of emphasis occurred in the management of AIDs; living with the syndrome and long-term management, rather than dying from it, i.e. from prevention to potential therapies. This has led to the emergence of a third paradigm that views AIDs as a perpetual infectious pandemic. This current paradigm accentuates the need to see AIDs as a biological and social disorder, whose aetiology, prevention and prognosis or amelioration requires attention to the social, economic and political context of sufferers. This collective epithet explicates the social construction of risk, life choices and therapies, as well as how gender, social conditions or power relationships may influence health status (Krieger, 1992). AIDs is understood relative to the social and political discourse of any given point in history and therefore not shaped only by biomedical advancements but also through the voices of those affected by the epidemic.

Of all the processes associated with AIDs, one of the most vital components is the way individuals on the AIDs spectrum recognise and evaluate the disease and illness. From a situation of where nothing unusual is happening to how they enter the

sick role and how they establish coping strategies for dealing with emerging problems. Sociologists have studied these social processes for AIDs and many psychosocial models of adaptation exist (Nichols, 1985). However, such models are useful analytical tools, but consideration must be given to the actual inchoate experience of disease that may not follow the exact order as explicated in the models.

HIV infection and/or AIDS may propagate psychological states, such as uncertainty and anxiety. Family, friends, medical professionals and faith leaders have a crucial function in aiding and supporting individuals with a positive HIV diagnosis. Emotional responses, such as fear, guilt, hopelessness and despair may develop in sufferers (Remien and Rabkin, 2001), as individuals try to integrate this new reality into their existing identity. The impact of AIDS on individuals, families, carer's and society is difficult to grasp. As nearly 50% of HIV positive cases are within women, further cases can be expected due to vertical transmission between mother and child. The stigmatisation of AIDs sufferers operates on an almost contradictory set of assumptions than the biomedical model. When analysing the stigma model, the disease is thought to reside not within the body but determined by individualistic behaviours and lifestyles. AIDs is conceptualised and explained not in scientific terms but morally and theologically through sin and evil, with grounding in two of the deepest and oldest structures of stigma; erotophobia and racism. The stigma model also manages AIDs not through drugs or hospitals but through segregation, discrimination and exclusion (Weeks, 1988 p.24). Like epidemic diseases of the past; leprosy and tuberculosis, and cancer in the present, AIDs has become synonymous and mapped to devaluation, dishonour and degradation; with a profound omnipresence of stigma. Some cultures have even tried to deny the

existence of AIDs altogether, due to the associated triple stigma; marginalised group, sexual transmission and terminal disease. The scapegoating of AIDs sufferer's feeds on the fears of permissiveness. This connection of disease and moral scapegoating has long historical connections (Porter, 1986).

Public Health narrative of AIDs

The causative agent of AIDs is the human immunodeficiency virus (HIV), which was first reported publicly in 1981. Globally in 2016 the estimated number of people living with HIV was estimated at 36.7 million, with an annual 1.8 million new infections (UNAIDS 2017), compared to an estimated 101,200 people in 2015 were living with HIV in the UK (PHE, 2016). Most of infections within the UK were passed on from person to person, who were unaware of their HIV status. Treatment with antiretroviral drugs for HIV infection has transformed infection with HIV to a manageable chronic condition, from a deadly contagion. People within the UK living with HIV are projected to have an average life expectancy if the diagnosis is not late stage HIV. The foremost mode is sexual contact (>75%), with vertical transmission (5-10%) (Lewthwaite and Wilkins, 2009). Synonymous to infamous epidemics of the past, AIDs manifested without warning, with initial infections manifesting in a marginalised community (homosexuals), at a time of notoriety due to its unparalleled growth and public presence (Weeks, 1993: 17). As a result, the epidemic was firstly labelled as GRID, the gay related immunodeficiency disease, however, this changed as cases emerged in women, injecting drug users and haemophiliacs (Fee and Krieger, 1993). The identification in 1983 of HIV as the AIDs virus characterised it as an infectious disease contagion, resulting in the loss of interest of the social factors accompanying transmission. Having said this, pluralistic ideas of disease aetiology

remained, which embraced; scientific, social, folk, traditional, magical and religious explanations.

Amongst healthcare professionals, the identification of HIV provided clear approaches for AIDs prevention. The emphasis shifted from risk groups to risk behaviours, i.e. specific acts rather than sexual identities. Campaigns to promote condom use to block transmission were being advocated, however, these were staunchly opposed by right wing conservative intransigents against non-marital sex (Fee and Krieger, 1993). On a similar vein, injecting drug users were provided with clean needles to prevent blood borne transmission of AIDs, which, again was criticised for encouraging drug use (Anderson, 1991). Such initiatives followed traditional individualistic infection control measures and failed to consider the social reality of discrimination and stigma individuals faced as HIV positive individuals (Mahajan et al, 2008).

Azidothymidine (AZT) also known as zidovudine a nucleoside reverse transcriptase inhibitor (NRTI) in 1987 became the first drug to be approved for treating AIDs by the US Food & Drug Administration (FDA). The development through the 1990s of additional NRTIs and treatment through highly active antiretroviral therapy (HAART) improved the life expectancy and prognosis in patients with HIV infection. However, the combination therapy had the potential for short and long side effects, as well as the development of viral resistance due to poor compliance (Lewthwaite & Wilkins, 2009). By around the late 1980s, it became evident that unlike previous epidemics, AIDs did not follow traditional bell-shaped plague models due to its long wave epidemic nature. As people with AIDs were living average life expectancies health professionals shifted the emphasis from prevention to therapies and from aetiology to pathology. This alternative paradigm better addresses the inadequacies of the

medical model through challenging the patterns of socially shaped risks and the role of health education to enhance understanding disease causation, prevention and treatment (Walsh and Bibace, 1990).

The predominant response of public health to the disease has been one that revolves around prevention through advocating ‘safe sex’ education and changes in sexual behaviour. As this measure traversed into the sphere of sexual ethics, it revived elements of the fear (AIDs) and evil nature of sex of earlier eras that focussed predominantly on the physical dimensions of sexuality. Under the banner of safe sex, measures such the use of condoms, engaging in non-intrusive sexual activity or promotion of values such as sexual abstinence and marital fidelity and monogamous relationships were propagated (Lebacqz & Blake, 1996: 262-265).

The ABC approach to prevention (abstinence, be faithful and condom usage) emphasised the responsibility on the individual and their moral agency through behavioural change (Wangen, 2010). The strategy depends on individual agency against a socially stigmatising and dehumanising infection that has caused an ethical storm (moral forest) on issues pertaining to disclosure, testing pre-marriage, breastfeeding and distribution of condoms to the youth; exposing the making of social structures (Dube, 2015). Response to the epidemic has also been characterised by both inertia and fevered activity, with the disease-specific response of the West referred by some as AIDs exceptionalism. Whilst the exceptionalist public health response has contained the epidemic in the West, AIDs still remains a major source of pre-mature mortality in many nations in Africa (Smith and Whiteside, 2010). El-Sadr et al (2010) commenting on the overlooked HIV epidemic in the United States highlights the health inequalities that persist and advocates

proportionate universalism approach as there is high prevalence in the deprived and marginalised communities relative to the low prevalence in the general population.

Theological narrative of AIDs

Since the beginning of the AIDs pandemic, the theological response from Christian individuals and institutions to those living with HIV/ AIDs has been variegated, ranging from providing care and support to assuage anguish to epithets of condemnation, immorality and deserved illness driving isolation and stigmatisation (Wangen, 2010). The spectrum of Christian responses from different denominations, such as Catholics or Protestants has stemmed from the challenge on the need to be prophetic, i.e. to reflect on the reality of the needs of people and deliver practical wisdom (Pendergast, 1990). One of the foremost raison d'être of Christianity (religions) is to provide individuals the ability to cope with the uncertainties, chaos and confusion of life through a framework of meaning, inclusivity and holism (Pattison, 1990). Christian theology and sexuality enquiries have often talked past each other or drowned each other. Any change or liberalisation to attitudes in sexuality within Christian ethics and denominations historically have taken a long time to adapt to new societal patterns values. The common assumption that Christianity's concern with the body is reducible just to sexuality is myopic and severely misconstrued, as for many Christians the body exists to perceive the glory of God (Imago Dei) through an embodied experience of human and divine (Harvey, 2002: 3-18). This can be achieved through the construction of the bodily liturgically, as it is a place of prayer and praise and a means of knowing God, i.e. the body is more than just physicality but a means of salvation (Rogers, 2002: xvii – xxii). In recent years there has been many developments in Christian sexual ethics that have emancipated from past focus of fear and physicality to viewing sexuality through

multiple levels of existence, such as the social and the spiritual (Nelson, 1983: 5-6). A holistic Christian sexual ethic is created from an anthropology of wholeness and relationality and not just premised on safe sex. The discussion of sex under the rubric of safety is often accompanied by fear, blame and scapegoating, where marginalised and risk groups are often stigmatised for bringing upon themselves the wrath of God by their lifestyles and are therefore defiled.

While banal provocative propositions are commonplace, thoughtful theological discussion is required to grapple the complexities of human sexuality, beyond discussion of morality and to the theological reflections regarding sexual diversity. For human beings, natural law proposes creative activities (fecundity) that express participating in God's providence and flourishing as intimates / members of the community, however, some advocate moving beyond the singular notion of procreative productivity, where sexual intimacy is a gift of God that produces traits of trust, companionship, mutual support and relationality (Iozzio, 2015: 539). The paradox of the church is such that on the one hand it condemns non-heterosexual acts, while it calls to accept all regardless of orientation, as all should be treated with compassion and sensitivity. The church needs to be taking a greater responsibility of bodies as well as souls, however, the response should be in proportion to the extent of the issue and should form part of a long term sexual health strategy or a critical theological discussion to inform secular policy development that aims to ameliorate the suffering of society (Nolan and Butler, 2018).

Church and religious communities need to be aware of stigmatisation as a device in the production of social order, where stigma can be utilised to enforce purity of belief with the threat of exclusion a deterrent to members to conform to beliefs, norms and values (Wangen, 2010). Just as social and political structures, religious communities

exercise power over their members. The stigmatisation within religious communities may also be compounded when the notion of an individual's HIV status is perceived as "deserved" due to them committing an amoral offence or sin. It is often those that already reside at the margins of society (least social power) that are identified as sinners, where such social sinners are a threat to the social values or order. HIV stigmatisation is an immense challenge for the Church, as the notion of sin is used as a marker to differentiate between those living with and without the condition. This essentialisation of HIV/AID as sin from immorality and sufferers viewed as unmerited bearers of the *imago dei* can result in the social construction of superior and inferior individuals in a community. This is contrary to the teaching of Jesus, when seen in relation to John 8:7, "let anyone among you who is without sin be the first to throw a stone at her.

The AIDs pandemic has seemed to reify an underlying rubric that has immersed humanity of a subconscious nexus between the body, sexual activity and subsequent illness as divine punishment. The essentialisation of sexual orientation in the post-enlightenment era and subsequent categorisation of people based upon their sexual behaviour caused mainly polemics in society, especially for Christianity. Although the Church was aware of same-sex sexual activity (regarded as sin due to it being contrary to natural law), it was regarded as a wilful perversion and a relatively facile issue, such as lying or stealing. However, as sexual orientation became accepted as scientific orthodoxy, the church was and is being challenged in relation to Biblical authority and tradition regarding homosexual activity (Thatcher and Stuart, 1996: ix-x). According to Nelson (1992: 21) contemporary theologies of the body are on two divergent paths, where the official churches are attempting to do a theology of sexuality. This is a unidirectional argument about what the scriptures

proclaim in relation to sexual diversity. Feminist, gay and other theologians on the other hand are seeking to develop a sexual theology, which asks how the experience of human beings as sexual beings informs our worldview regarding practical application of scripture and tradition.

Biblical interpretation is not just about quarrying for historical facts or revelatory propositions like an archaeological dig to reification or absolutism of certain positions on issues. It instead should be utilised as a means of learning and transforming enactment, rather than being placed on the dock. Issues such as sexuality should be posed around questioning and challenging the church around the experiences of men and women in church and society, so that it can be interpreted to give life in today's world (Barton 1996: 4-11). This form of practical theology will however, require individuals to take responsibility for the way they "perform" the Bible in ways that will engender practical wisdom and productive opportunities, i.e. phronesis and poiesis.

Current challenges of the church and AIDs

Even as we approach the fourth decade of the AIDS pandemic, there is a great deal of ambivalence on the theological and societal response of the Church. Many people of faith; clergy and congregants are unsure of what can be done to reduce its mortality and morbidity, with many responding with anathemas to those infected with moral condemnation rather than supporting relief or developing public policy to protect those are greatest risk or vulnerability (Iozzio, 2015: 550). AIDs has challenged humanity and made judgement at many levels of existence within society ranging from governmental policy (macro) to the suffering of the individual (micro) – a mutual double judgement (Pattison, 1989: 130). Despite the multiple possible routes of HIV infection most of the focus of faith groups has been on sexual intimacy

(homosexuality), where many of the heteronormative discussions have been counter-productive due to the notion of AIDs as a punishment for wrongdoing.

AIDs has bought judgement on individuals and society as it has launched to the fore debate on sexual morality. For some Christians, AIDs is a punishment from God for those engaging in the sinful practice of homosexuality, whilst for others it is a debilitating disease caused by a virus that affects homosexuals and non-homosexuals, vertical transmission during pregnancy and haemophiliacs. The varying personifications and metaphors of AIDs demonstrate the inability to comprehend the reality of disease and illness, each immersed within specific social values (Pattison, 1989:136-139). This sin narrative of AIDs has perpetuated the exclusion, marginalisation and stigmatisation of those living with AIDs, as well as propagating structural sin and social injustice (Wangen, 2010).

The emergence of new paradigms or frameworks of understanding occur when the elucidatory capability and capacity of the old wane. These transformations and ruptures are especially precipitative during times of crisis, such as the current AIDs crisis for the church. This crisis calls the church to face its sexual ethics and assess its proclamations or preventions regarding sexual pluralism and whether it allows individuals of all orientations to enter God's salvific love of humanity (Lindsey, 1996: 347). Many parts of the Christian church have responded with alacrity to the AIDs crisis through supporting hospices and enacting its evangelical vocation of healing; however, this response to AIDs sufferers is not without irony. The presupposition of many within the church that a homosexual orientation is intrinsically disordered and thus the healing concern appears to someone other than the patient themselves, i.e. bodies are separated from psyches (Lindsey, 1996 p.349). The implications of this approach to healing regarding the AIDs crisis have had many ramifications. If

homosexuality is a phenomenon that the church believes it can cleave from an individual's personhood, healing will not occur, as sexual orientation cannot be detached from an individual's cognitive composition. Due to the existence of a dualism contained in the church's worldview of human sexuality, sexual acts are often judged separately from the human agent. This divorcing of sexuality from the person is contrary to the healing ministries vocation of healing the wholeness of the person. It is also opposing to the notion that healing is to enter the sufferer's existence (Hauerwas, 1986: 165). Another contention of the church's response to AIDs is related to the need to consider the social space of the person. Rather than being a univocal category of disease classification, health, healing and illness are social constructions. As the impact of society on individuals is variable, the therapeutic culture of society challenges the privatised understanding of illness and therefore the social construction of AIDs must be a key component of the church's response to AIDs (Bloch, 1986: 465), i.e. a social healing social space for those suffering stigmatisation. In ecclesiastical terms, AIDs provides a light and a dark Kairos, as the continuation of a physicalist moral assessment will lead to condemnation and brokenness of individuals with AIDs (dark Kairos). However, a paradigm shift in sexual ethics that considers the whole person and social ethics provides a light Kairos, where the societal matrix is contemplated to ameliorate suffering from AIDs (Lindsey, 1996: 352).

If the church is to develop solidarity with sufferers then it is required to considers itself as one body and willing to suffer with its congregants as if "The Church has Aids" and thus acting as a healing and an embracing community. As stated in (Romans 15:7), "Accept one another, then, just as Christ accepted you". The stigma and ostracism faced by AIDs sufferers runs contrary to the notion of *Imago Dei,* as

this is not diminished due to an individual's physical condition. The experience of HIV/AIDs epidemic for clergy and congregants has been an apocalyptic text. It has also revealed multiple ethical fractures in social structures and the requirement for a sexual health ethics theology in relation to STDs (Dube, 2015). The need for a HIV positive church arises from the united determination to confront the stigmatisation and discrimination associated with the HIV epidemic and draws from Jesus' association with the marginalised (Matt 25: 31-46) and Pauline notion of the church as the body of Christ united in pain and joy (1 Cor. 12:26). The HIV positive church is built on *ubuntu* (African ethics on humanity and recognition of the other) and has the following traits:

1. Centres on the other by identifying and hearing the marginalised, discriminated and oppressed to provide a space to live the dreams of liberation
2. Lives with the virus to understand and work through exposure and ameliorate the pathologies in social structures to work towards a holistic liberation
3. A healing community, i.e. the image of God in all
4. Valorise the living and commemorating the dead
5. Working collaborative with wider societal structures to perform resurrection acts against oppressive structures

The AIDs pandemic requires a re-alignment of our theological thinking; as was after other social crises after the holocaust or apartheid in South Africa, i.e. a "theology of Aids" (Naude, 2005). The church cannot continue as nothing is happening and needs to develop a systematic theological response regarding AIDs that is cognisant of societal norms and cultural heritages. Christian churches in endemic areas find it challenging to engage with AIDs issues, as there is not:

1) A reflective theological map on STDs
2) An openness to publicly address issues of sexuality
3) A systematic approach to issues of inequalities (gender, health) and sexism (Achilles heel of church).

In order for the church to provide an effective pastoral counselling enterprise to those directly (individual) and indirectly (family, friends and carers) affected by the scourge of HIV/AIDs, it is necessary that it adopts a broad philosophical social-psycho-physical perspective. This will allow the amelioration of the stigma on a community and societal level, as well as liberating the perturbed minds of those infected with the virus from their identity as a composite human consisting of a body and soul (Chukwu, 2004). Pastoral counselling can provide individuals with consolation and spiritual inspirational during this perplexing and emotional time of ill health; however, it is apt to note that the meanings of the bodily life or death are not the same to everyone. Therefore, regardless of an individual's theistic or atheistic orientation, pastoral counselling as an encounter should enable an individual to help discover their wholeness, eliminate anxiety and restore hope. It is essential for pastoral counsellors to tackle and confront the stigmatisation of AIDS under the Biblical tenet that "we have all sinned" and extending support to those infected with AIDS in terms of spiritual, psychological and material support, as pastors are in a position of power to diminish the stigma of HIV/AIDS among congregants and the wider community. The predicament of HIV/AIDS may cause an individual and his family feelings of severe demoralisation, disappointment and abandonment from God and thus it is essential for pastoral counsellors to help support and provide spiritual sustenance to such individuals at a time of depleted faith (Chukwu, 2004).

The crisis of HIV/AIDs constitutes a critically opportune moment for the church. The pandemic pertains to the moment (kairos) where the church is required to re-examine, reflect and re-appraise its theology and praxis to elucidate the revelatory meaning of the crisis (Baard, 2008). Interaction and dialogue of the church with its congregants and involvement with localised public health teams can help develop tailored community AIDs prevention programs influenced by both worldviews (Isler et al, 2014). The challenge is to bridge the associated meaning of the sacred and secular models of prevention (sin or disease) and synergise perspectives. Further enhancement of knowledge by professionals from both the church and public health is required. The comprehension of their respective action guiding ideologies is crucial to help those at risk of HIV/AIDs through a clear and consistent response to prevention (Rakotoniana et al, 2014). Kairos and practical theology are not only concerned with an abstract faith concerned with eternity but rather attempts to tackle the contemporary situations and issues of people, a church that engages through relativism and challenges theological norms. Some of the key elements of the kairos of AIDs is to challenge the status quo theology and actions of public health regarding gender inequalities and stigmatisation. The kairos of AIDs theology needs to adopt a whole complex systems public health approach (Rutter, et al 2017), requiring it to focus on structures that ameliorate or perpetuate stigma of AIDs at individual, community and societal level.

COLLABORATIVE COMMUNITY HEALING

Outline of chapter

This final chapter of the thesis will collate the findings from the intellectual archaeological review from the depression and HIV/AIDs case studies. The results will be categorised into sub themes to identify the opportunities and obstacles of collaborative healing.

Collaborative healing

Compassion, care and cure for those afflicted with illness can take many forms within preventative public health and Christian healing as they have converging and diverging values and agendas regarding health and healing. Within the UK, Christianity was instrumental in the provision of healthcare and development of hospitals. Any discussion of collaborative healing must acknowledge the complexities of the collaboration of these actions guiding worldviews through cognisance of factors that may facilitate and inhibit such partnerships (Kegler et al, 2010). The aim of this thesis was to identify the opportunities and obstacles of collaboration between Christian healing and preventative public health for health improvement within the UK. The examination and review of the ideologies of these action guiding worldviews and interactions was conducted through a practical reflective theological “critical conversation” approach. This dialectic revealed the potential barriers and benefits of collaboration, as highlighted through the two case studies of depression and AIDs. The opportunities and obstacles were explored using a thematic analysis approach to generate codes and themes (Tables 1 and 2).

Major findings in relation to the obstacles (Table 1) for collaboration from this review have been that; i) there currently is very limited or systematic dialogue between public health and Christian healing. Although many partnerships have been

highlighted within (Demos, 2013 & 2019; LGA, 2019), however, much of this narrative been framed around the constrained finances of local government and the NHS and as a result, public bodies are utilising the social capital within their areas to harness the local assets for health improvement. The contemporary increase in partnerships because of austerity measures also is a threat to future viability of partnerships (Demos, 2019; 19). A central driver that maybe exacerbating this absence of dialogue is the lack of communication between these healing centres. Secondly, religion and health are societal mirrors of each other and it is only through a deeper understanding of each other's worldviews through multiple dialogues at multiple levels can there be a meeting of a shared experience or collaborative healing. Both public health and Christian healing need to take a more corporate or holistic role in the health and wellbeing of their communities. This communal outlook to health and wellbeing for both worldviews can be inculcated through the increase of literacy, i.e. religious and health within the public and professionals. As well as this, there is a need to gain a better understanding of the pluralistic healthworlds of communities. Third, there is a major dearth is the evidence base that demonstrates the effectiveness of faith and health partnerships as outcome-based evaluations are rarely performed. I will explicate some of the other obstacles in the obstacles section. Finally, the case studies also highlighted the complex nature and role of stigma within public health and Christian healing, as the partnering of these worldviews could either facilitate individuals with AIDs or depression to engage with preventative efforts or perpetuate social isolation. In terms of opportunities (Table 2); by taking a multi/interdisciplinary approach, such partnerships consider the complexity of health systems and don't assume linear causal models. Secondly, collaboration can aid dialogue and therefore open a vast number of doors, such as increasing religious & health literacy or conducting joint research to answer local need.

Within local areas, faith groups can act as significant allies of public health due to their mutual concerns of health and healing. Over the years, a range of partnerships that depict a continuum of relationships have formed (Idler and Kellehear, 2017). The consonance of the ethics of public health and Christian healing on many levels (individual and population), such as communitarianism, stewardship and their prophetic roles to petition social justice regarding disadvantage and disempowerment (Levin, 2013) outline driving values for collaboration.

At the core of the debate to the collaboration of public health and Christianity is why now? One of the major recent political drivers was the UK government 'Big Society' agenda of 2010. It aimed to reconfigure relations between state and society by redistributing power to local communities and engender a process of social and cultural renewal. This shift emphasised limited reliance on the state for provision of services and avowed notions of decentralisation, localism and the empowerment of community groups and therefore enlarging the role of voluntary sector and faith based organisation in the role of delivery of services. There was however, ambivalence of whether the drivers for the big society were that faith organisations had a superior propensity towards voluntaristic activities or a desire to displace responsibility of welfare provision on faith organisations (Kettell, 2012). A 2015 audit (Civil Exchange, 2015: 4) found that 'Big Society' had failed to deliver its original goals of creating more social action, empowering communities and opening up public services. It recommended the abolition of market / neoliberal based public sector management with a more collaborative one that was focussed at devolution of power at a local government level and targeting those in greatest need. The following sections will discuss the opportunities and obstacles in detail.

Table 1 - Obstacles for collaborative healing

Obstacles	Communication	No common language
		Critical / mutual dialogue
		Understanding complexity; economic, social, political
		How to communicate with and with whom?
		Mistrust – intra / inter organisational
		Factors that influence health and illness
	Health effects	Negative
		Psychopathological
		Suffering in silence
		Increases stigma
		Widen health equalities
	Worldviews	Literacy – Public health & Christianity
		Need to consider whole of worldviews
		Domination of secularisation
		Paradigm Imperialism / ideological erosion / complexity
	Measurement of Impact	Evaluation
		Outcomes / outputs
		Dearth of evidence base
	Funding	Austerity
		Loss of autonomy
		Sustainability
	Institutional	Internal / external conflict
		Loss of autonomy
		Mission creep

Table 2- Opportunities for collaborative healing

Opportunities	Access	Contact with faith institutions
		Interaction with vulnerable populations
	Context	Identifies research gaps
		Transformative / Innovative
		Zeitgeist
	Health Improvement	Reduction of health inequalities
		Prevention across all domains
		Tackles current issues
		Addresses wider determinants
		Reduces stigma
	Systems / Disciplines	Whole system
		Multisectoral
		Interdisciplinary
		Sustainable
	Community	Stewardship
		Social value
		Service to others
		Community cohesion
		Healing
		Reduce stigma
		Erase boundaries of sacred and secular
	Individual	Meaning / purpose
		Fellowship
		Praxis of faith
		Wholeness
		Healing
		Reducing stigma
		Understand health behaviours / health worlds

Opportunities for collaboration

Many faith groups have been tackling the health needs of communities for centuries internationally and within the UK. However, they are not the first choice for seeking health in contemporary times due to advances in technology and finances within secular science and the dominance of the biomedical model of health (Duff and Buckingham, 2015). As discussed in chapter three regarding the ideologies of public health and Christian healing, both action influencing worldviews share many values but differ in aetiologies of health and disease. For public health, epidemiological data, i.e. worldview of factfulness confers ultimate value on population and community health, while for Christianity, it is the scriptural and doctrinal edicts that are authoritative and influence communal relationships and God. Therefore, building healthy communities in which coexist a myriad of worldviews, it requires the realigning and mobilisation of values though social change to develop a common language (Gunderson, 2000).

Many local authorities across the UK have started to develop a more comprehensive approach to working with faith organisations and thirds sector (voluntary and community sector) organisations as part of asset based strategic planning collaborations. A 2017 report by the Local Government Association (LGA) and Faith Action provides examples of productive partnerships between local authorities, NHS and faith groups contributing to community health and wellbeing and wider social action. Asset based community work skills are advocated and the need to establish relationships between faith and statutory organisations that build on strengths. This can only be possible with the initiation of some sort of critical and mutual dialogue. A key consideration that needs to be acknowledged is the idiosyncrasy between faith

based and faith placed action, where the former action is inspired from faith groups, such as lunch clubs for homeless (service), whilst the latter is action, where external organisations carry out interventions at a place of worship, e.g. smoking cessation sessions (Local Government Association & Faith Action, 2017: 3-4).

The contribution of many faith-based organisations, such as churches to population health improvement and mirroring public health is often downplayed due to the lack of comprehension about the range and reason for their involvement in community health enhancing initiatives (Dejong, 1991: 2). The linking of community and public health interventions has many benefits, due to its capacity and capability in involving people from underserved areas accessing clinical and preventative services. It also facilitates compliance to treatment regimes and provides a nuanced understanding of the health inequalities and wider socioeconomic determinants affecting health within these often hard to reach communities (Magezi, 2012). The role of faith organisations is often either not recognised or sufficiently amalgamated within conventional health systems. Tomalin et al (2019) argue that religious organisations within the UK form key components of therapeutic landscapes within communities and have the ability to combine sacred and secular transformative holistic healing.

The drive to develop the infrastructure of the healthcare sector within countries through community approaches can be seen to be promulgated through the WHO Alma Ata Declaration of 1978. This declaration emphasised a broader conceptualisation of health and wellbeing compared to the myopic dominance of the biomedical model and promoted a multi-sector, multiagency and interdisciplinary approach to health care (Gilliam, 2008). The shifting global and local health trends and economic realities within pluralistic societies have mandated for closer collaborations between faith and governmental health care provision. Faith based

and faith placed health care provision can provide capacities of coverage, sustainability, infrastructure and scale and can contribute to community health holistically. One of the desires to explore the interaction between health and faith within the sphere of population health improvement has emerged from the equivocal secularist philosophies around the decline of religion as an identity in 21st Century society (Martin and Catto, 2012). Many Twenty-First Century sociologists of religion agree that religion never went away (Woodhead, 2012; Davie, 2015;) but rather how religious belief, belonging and behaviour within the private and public spheres has changed.

The shifting of churches and other community based organisations from the margins to the core of community based health care provision can occur due to the opportunities that emerge from the Church's duality of function; substantive message and praxis. The substantive message of healing drawn from the Bible through models of the Shepard, wounded healer and paraklesis propagates living and draws from its communal infrastructure and action guiding worldview to promote health and wellbeing, in order that individuals can maintain their relationships with God and his creation. The interaction of churches and formal health care varies and therefore due to the heterogeneous nature, it is not possible to have a generalised model about the health improvement or healthcare provision activities provided by faith organisations (Magezi, 2008).

Partnerships of religious and medical institutions have shown to have the ability to effectively undertake primary, secondary, tertiary and quaternary prevention initiatives by implementing a holistic preventative health model. These partnerships have been especially effective in reaching minority communities (Bennett and Hale, 2009: 3-5). One of the major driving forces for faith-based and faith-placed

organisations to deliver public health services is the inability of mainstream health services to interact with particular communities, leading to a growing unmet need in many communities. Another motivational reason for faith organisations to conduct health improvement functions is their ethic of service to others and their desire of developing community coherence.

The renewed visibility of religion in the public sphere and in healthcare provision in recent times has led to what appears in the global West occupying a liminal space in relation to public talk of religion. No road map, however, currently exists on how religious and secular forces will interact and emerge to conduct population health improvement within the public sphere, each guided by their action guiding ideologies or whether there will remain a constant fluid norm, driven by innovation and globalisation (Dinham and Baker, 2017). The materialisation of a religiously plural public sphere in contemporary UK society necessitates current policy making that is efficacious and context specific and built on the strengths and assets of local communities. It is in this context, that there is an urgent need to comprehend the obstacles and opportunities between religious / secular organisations and ideologies, in order that they operate and be able to contribute to local communities mutually (Dinham, 2018). The challenge is both practical and conceptual, as how do intersectional action guiding ideologies, such as public health and Christianity engage with greater secularity and plurality. The major conceptual challenge is the ability to foster interdisciplinary dialogue in order to understand the classic epistemologies and binaries that exist and motivate action across both worldviews (Dinham and Baker, 2017).

A dearth of research exists that examines the health care related controversies between and within religions and therefore there is an urgent need for innovative research to build up the evidence base that elucidates the barriers of collaboration but also highlights examples of good practice that can demonstrate the benefits of collaborative healing (Tomkins, et al 2015). To deliver compassionate and empathetic care, healthcare providers need to have an understanding on how individual and community religion may drive the actions, attitudes, prejudices and responses to health and illness. It is also incumbent on religious leaders to review the relevance of sacred texts in interpreting contemporary biomedicine and whether faith informed messages can inspire congregational adoption of healthy behaviours and increase access to healthcare services. Hospitals and congregations are required to work collaboratively as it is their patients and members, who at various points in their life are going through there doorways and therefore they both form an integral part of the healing therapeutic community. Institutional alignment of public health and Christian healing will allow a better continuum of care due to the complementary and mutual healing concerns of these health worlds (Gunderson and Cochrane, 2012: 169-170).

Many religious and faith communities, especially in Africa responded to the AIDS pandemic to try and reduce the stigma and discrimination associated with the illness. It is estimated that around 20% of the organisations working and providing AIDs healthcare are faith based organisations (WHO, 2004). The stigmatisation towards AIDs sufferers is conceived to have developed and accentuated from cultural beliefs and interpretation of religious edicts (rejection of homosexuality) that resulted as severe obstacles to the AIDs response (UNAIDS, 2012: 84). UNAIDS developed a strategic framework for partnerships with faith based organisations that promoted the

creation of partnerships based on mutual trust and respect. The framework was about how joint action could better achieve joint goals and delivery of non-judgemental, evidence informed health care by religious, governemental and non-governmental organisations to tackle the AIDS emergency (UNAIDS, 2009: 15). In terms of joint provision within the UK, Positive Faith, a network of Christians in Britain and Ireland addresses AIDs through the context of faith and explores how the church can be a space to giving people a voice to people undergoing health and other personal issues (McManus, 2017). Catholics for AIDS Prevention and Support deliver this project helping people of Christian faith to understand their health experience.

Research on faith-based providers (Demos, 2013: 139-143) found little evidence of proselytization of service users and found them to be effective partners to deliver public services. Faith based providers were motivated by “living their faith” demonstrating equity of provision to members of different faiths or no faith. Religious organisations were often the permanent and persistent pillars (anchor institutions) of community action within local communities that harnessed substantial social capital and desire to motivate individuals and communities to address their social problems. Government and non-government funding of local faith organisations should consider additional social values, such as recruiting employees in the local area and addressing roots of social justice problems.

Within the UK, faith based organisations have been profoundly influential in the development and evolution of homelessness services. The provision of basic food, shelter and clothing ‘hospitality’ services coordinated by faith organisations are resourced predominately through charitable provisions, whilst specialist support homeless services, maybe provided by a faith and secular agency partnership. Many

faith based projects are staffed by people with faith, no faith and different religious backgrounds, where the faith affiliation is now evident in palimpsest only (Johnsen, 2014). Case studies involving interviews with homeless people in London and Manchester reported that it was challenging to determine any systematic distinction between faith and secular homeless provision. Both providers acknowledged the value of supporting people in developing their sense of meaning, identity and purpose including following a faith or other ideology. The ethos of many faith based services departed significantly from rehabilitative approaches and were dominated by 'non-interventionist' (open door policy, few questions), while secular services tended to be more interventionist (commitment to defined support plans) with rehabilitative measures as promoted by central and local government (Johnsen, 2012: 295-298). The interaction of faith based and secular provision for the homeless highlights the diversity of contemporary homelessness services and in the wider context of healthcare provision and the often blurred boundaries in delivering services. In describing the diversity of the range and level of collaborations between faith and health organisations within the US and UK (Idler and Kellehear, 2017) propose a continuum of religious presence to delineate the variance. This taxonomy (Table 3) ranges from fused identities (faith saturated) to discrete entities (faith-secular partnerships).

Table 3 - Taxonomy of religious presence in healthcare organisations

Intersectional Category	***Description***
Faith Saturated	All resources, staff and service users are of a particular religious group
Faith Centred	Funding from government and religious groups. Strong religious identity that serve users of different religious backgrounds
Faith Background	History as faith saturated / centred organisation. Mostly secularised funding, serving those of different religious faith or no faith
Formal Faith Role	Institutions that have secular origins (hospitals) but incorporate formal role of religious services; chaplaincy, spiritual care
Informal faith role	Ordinary informal religious interactions between staff and patients
Faith-secular partnerships	Faith organisations partner with governmental agencies / sectors clinics to provide services to their community members

The intersection and encounter of individuals and institutions involving religious congregations with local and national healthcare providers are useful complements to the state in the current climate of healthcare resource scarcity. These encounters past and present can be described as “a messy story” (Cadge, 2012:14) of conflict and cooperation and therefore intersections are diverse producing opportunities and obstacles for collaboration. The interactions of faith-based and preventative public health contain a plethora of collaborations that entail primary / secondary care, policy making, prevention interventions, voluntary and community organisations to tackle the diverse needs of congregations and the broader community. In order for these collaborations to flourish, public health as a discipline and function within local government requires to emancipate from itself any underlying or preconceived suspicions of community, faith-based organisations and wider voluntary sector organisations in order to capitalise from the underused potential they have to improve population health. Similarly faith based organisations need to engage with the public sector and reclaim their prophetic voice regarding devotion to justice, mercy and communitarian concern to address health and societal inequities affecting vulnerable populations (Levin, 2014).

A UK inquiry conducted by Demos, (a cross party think tank) in 2013 investigated the character, capacity and consequences of faith in British society and politics. The inquiry produced a compilation of reports; faithful politics, faithful citizens and faithful providers. Its commentaries concluded that adherents of faith groups have the capability and capacity to influence and make a difference within British society and through progressive politics contribute to social reform within the UK (Demos, 2013: 11). The faithful providers section reported findings that assessed involvement of faith groups providing services to the wider community. It construed that faith

providers were able to deliver effective services thorough high levels of motivation and there was no evidence of zealous evangelising or prejudice on the grounds of religion (Demos 2013: 12). A recommendation from the faithful providers report proposed local areas (local government) to undertake an audit of faith providers to gain a better understanding of faith-based provision within local areas. The audit would be able to highlight opportunities and obstacles of collaborative provision and whether the provision was appropriate to need of local communities.

Cinnamon Network UK, a Christian charity that connects faith-based organisations to deliver local transformations in communities conducted an audit during 2015/2016 to assess the current level of faith organisations social action community work (Cinnamon Network, 2016). The online survey audit found that around 3,000 local churches and other faith groups were actively supporting their local community through nearly 200,000 volunteers and generating 5.1 million beneficiary interactions each year. Nationally, the time faith groups invested within these projects was estimated to be worth over £3 billion a year. The audit aimed to highlight the social impact of churches and other faith groups and be used as a facilitator to help these organisations to develop further conversations and form partnerships with a range of organisations and sectors across society. Churches and other faith groups were found to be meeting a wide range of needs in the community, such as supporting families, children and young people, foodbanks, healthcare and job clubs. Many of the initiatives were across the life course and provision was of equal measure between the genders. In terms of levels of activity within England, each faith contributed an average of eight social action projects. Although, Cinnamon Faith Action made attempts to widen the response across faith groups; 94% of the respondents were Christian (Cinnamon Network, 2016: 8). This over-representation

of Christian organisations compared to the national percentage of Christians (60%) reported in Census 2011 may have led to an underestimation of the contribution by other faiths.

Current policy from the UK government on public health and its interaction with local communities was released earlier this year within the NHS Long Term Plan. The plan outlines proposals on how the government and the NHS will support wider social goals and play a wider role in influencing and shaping local communities (NHS, 2019: 116-120). The involvement and empowerment of local communities are fundamental to local and national health improvement strategies, particularly within vulnerable and deprived groups. A greater nuanced understanding of religious communities, organisations and dynamics is imperative through the development of interdisciplinary collaborations (Lindsay et al, 2014:4) to enable collaborative healing.

Obstacles for collaboration

Relatively little exists in the research literature on interdisciplinary or boundary transcending integrative collaborations of public health and Church partnerships (Kegler et al, 2010). On the whole, faith-based healthcare providers have been neglected in the recent past by the worlds of research and public health policy due to the dominance of the secular worldview, mistrust and controversies regarding proselytisation. However, the World Health Organisation (WHO) in line with its holistic understanding of health has pushed towards better understandings of the contribution of community and faith groups and alignment with governmental healthcare systems (World Health Organisation, 2004: 46).

The partnering of religious and faith groups with governmental healthcare providers requires a critical and mutual dialogue. This necessitates a holistic acknowledgement of the reality of religion as a whole way of life and not mere

consideration of certain rituals or beliefs that align with their worldview of health or healthcare institution (Pattison, 2013). It is however very difficult to attribute accurately individual viewpoints of health based on religion alone, as variations maybe due to culture, education, economics and politics that may modify interpretation of sacred texts and subsequent action (Tomkins et al, 2015). Religion based and secular ethics corroborate but also differ in many ways. They both regulate human behaviour, however differ with public health deconsecrated and based on humanistic values of autonomy and beneficence. Whereas Christian healing is extrapolated from interpretations of sacred texts and may place more of an emphasis on the sanctity of life and human duties (altruism) rather than human rights, which may override the importance of autonomy (Tomkins et al, 2015).

Theistic and non-theistic religions as action guiding worldviews continue to shape society and impacting the lives of individuals that ever increasingly within the UK are residing in religiously diverse and pluralistic communities. Mutual understanding and religious literacy between religious individuals, communities and the government is essential if health policy is to engage effectively on health related religious issues. This requires public health and the Church (faith organisations) to equip people with the knowledge and skills to facilitate dialogue to discuss barriers and benefits of collaboration confidently, accurately and critically. Poor religious literacy can perpetuate certain stigmas and stereotypes about some groups and lead to over simplistic suppositions on people's values and action guiding ideologies (APPG Religious Education, 2016: 3-4). The training of civil servants and wider employees of the public sector on equality and diversity, including religious literacy is recommended by the APPG (APPG, 2016:51).

Not all religious and faith-based groups would be interested in partnering with governmental health provision or integration with the public sector. One of the major challenges to interpreting the impact of health care provision delivered by faith groups is due to the complexity and heterogeneity of these groups (Olivier et al, 2015). Religious groups can facilitate and reduce the complexity by organising across geographical or denominational boundaries and creating shared frameworks to assist understanding of intra-inter religious distinctions. This greater efficient mechanism of engagement could contribute to providing culturally appropriate services, stable service delivery and funding. At a governmental policy level, poor estimates of the magnitude and impact of faith organisations can be detrimental for collaboration, as the distorted (overestimation and underestimation) may lead to push-back or commissioning of the incorrect services and mask important local characteristics (Olivier and Wodon, 2012).

The partnering of governmental organisations and religious groups to deliver health goals needs to be grounded in respect, autonomy and a common vision to ensure the wellbeing of religious and non-religious adherents. The belittling of each other's action guiding worldviews is detrimental to advancing partnerships and therefore governmental (national and local) policy is required to liberate itself from the myopic view that faith or religion is inherently maleficent to health. Conversely faith groups cannot undermine public health practice to conflate health and religious imperatives (Duff and Buckingham III, 2015).

Some religious organisations may be reluctant to align themselves with governments due to the mistrust of politics, political parties and popular polemics. (Demos, 2013: 19). Concomitantly, many in society may not endorse the potential of religious groups playing an undertaking responsibility of healthcare delivery due to

perceptions of poorer quality services and poor governance compared to public service counterparts (Olivier et al, 2015). The mixing of theology and healthcare policy have in some cases documented deleterious outcomes for health; sexual and reproductive health (Tomkins et al, 2015). Despite these trepidations from both worldviews, many faith-based organisations are engaging with local and national governmental system of health system to deliver collaborative healing. These collaborative initiatives are being conducted through the alignment of priorities and agreements that may provide funding, training and greater access to health services for local communities (Local Government Association and Faith Action, 2017: 3).

As well as on an individual level, collaborative health initiatives may have undesired outcomes for faith-based organisations delivering healthcare provision. Many congregants and faith leaders are uneasy about these partnerships and the possibility of asymmetric relationships, such as the funding “strings”, which may result in the loss of their autonomy and identity (Hiemstra, 2002). Faith organisations also consider the dependency of fiscal resources to deliver health care from governments as a type of ‘mission creep’ that could attenuate and distract from the core theological mission of the organisation (Tesoriero et al, 2000). Having said this, there is the propensity of many faith organisations the aspiration to collaborate with public sector partners, such as health and social care to facilitate health improvement within local areas. However, infrastructural capacity especially from smaller organisations, such as the knowledge base and skills to manage and evaluate grant programs are often lacking. It is therefore indispensable that faith and health partnerships engage in critical dialogue, so that they are able to understand the needs of each other’s ethical, philosophical and practical concerns, in order that

a clearly defined partnership can synthesise greater health benefit to followers of both worldviews than either could achieve alone (Brooks and Koenig, 2002).

Within the UK, public health and social care practice occur in a diverse social milieu of values, beliefs, religions and no-religion. The Department of Health reports that although the vast majority of patients express religious needs, however, less than half are queried regarding their theistic or non-theistic needs when interacting with the NHS (Dinham, 2018). An example of the recent eschewing of religious frameworks to health and wellbeing from public sector guidance can be gleaned from a recent guide produced by PHE and NHSE. The community centred approaches for health and wellbeing contains no explicit mention of religion and mentions “faith settings” once (South, 2015). Whilst educational, healthcare and infrastructure institutions within communities are often viewed anchor institutions (NHS, 2019), faith organisations are seldom considered in this context, despite their existence as core fixtures in local areas. Factors such as migration and globalisation have resulted in professionals working in the health and social care sectors to encounter a growing plurality of religions and beliefs within the UK. Health improvement through the “whole person” and “whole systems” approach requires a wholesome understanding of individuals and their communities that includes comprehending worldviews, which may help or hinder health improvement. The curricula of many health and social care professional education is largely dominated by secular assumptions, with seldom reference to social capital within religious assets. References within policy documents, regulations and guidelines concerning religion and spirituality are hinted at minimally and are largely undefined and often non-operationalised (Dinham, 2018). The paucity of UK national or localised guidance

has resulted in the heterogeneity of approaches to collaboration of faith and health groups which have developed organically in local areas.

The current cultural and political climates have demanded greater co-operation and joint funding of faith based organisations and publicly funded health care services. The additional funding to community based organisations have demanded extra mandated administrative functions of audit, accountability and evaluation. The call to evaluate faith based programming has increased in recent times to determine whether the faith factor can add value and whether these collaborations are more effective than secular health programme provision. It is therefore crucial to understand how faith based programs approach programme outcomes and evaluation (O'Connor and Netting, 2008). Evaluations of faith based organisations remain underdeveloped in addressing the underlying worldviews of research beliefs; ontology, epistemology and methodology and are therefore at a formative stage relative to other evaluation techniques (Janzen & Wiebe, 2011). There is no cardinal approach that are specific to religious or spiritual elements of faith based programs, as well as a paucity of participatory action research. This has resulted in many faith based organisational evaluations conducted with secular evaluation methodologies. As a result, many evaluations usually don't consider faith as a pragmatic component but consign it to a contextual component. Evaluated research, which has reported on the efficacy and added value of faith based organisations infrequently reports on how particular elements of religious practice (fasting, prayer, rituals) are associated with positive and effective outcomes, i.e. they are scarcely on logic models as descriptors of change (Ferguson et al, 2007).

One of the major publicly perceived barrier of partnering of faith and health organisations to deliver healthcare is the fear and distrust of faith organisations

(Kegler, et al 2010). This distrust stems from the perceived notion of a hidden agenda of the motives of the faith organisation, which may attempt to convert people covertly, whilst providing healthcare. The fear of proselytism is related to two concerns. Firstly that service provision will be conditional on faith and secondly that activities will be accompanied by coercive forms of faith sharing (Demos, 2019:12). In order to alleviate this concern, faith groups need to be upfront on how they want to talk about their faith through their social action. Secular partners also need to acknowledge that faith groups will often be motivated by their faith to take part in the common good. Many smaller faith organisations can struggle to form partnerships or grow existing and maintain continuity of services, due to the reliance on volunteers, as the regular changing of personnel makes it hard to build personal and consistent relationships with organisations.

By Christian organisations taking on roles previously provided by the state, faith groups may be unintentionally preserving a dysfunctional system and be perceived as becoming an arm of the state. By filling the gaps, the injustices of the government will continue and may run contrary to the values of the Church and feel as if the Church is being co-opted. This paradox of justice and mercy needs to be considered and addressed, as it may be perceived that while the Church is being merciful the injustice of the state continues (Demos, 2019:18-19).

Practical theology and health and religious literacy logic model

The dominance of the Western world intelligentsia and current UK society by Enlightenment rational instrumentalism has led to the decline of commitment and meaning to God in everyday life. Christian theology within the UK seems to have lost the power to transform, inform or reform the public at large. It has become deficient at expressing itself in an enlivening or an imaginative way that allows people to reassess their judgements and positions in relation to this action guiding worldview within a postmodern world that is pluralistic, fragmented and unstable (Pattison, 2000).

Understanding the multiple action influencing worldviews within society is crucial to dialoguing between various contexts and exploring the significance of the 'really real' for individuals and communities. In formulating public health and social care policy, many rational decision makers avoid the complexity of the community in favour of simplistic causal pathways that omit physical, mental, social and religious dynamics (Gunderson, 2000). Christian theology needs to make itself relevant and applicable to public service decision makers if it desires to be part of the dialogue regarding collaborative healing. It needs to focus not just on believers but give considerable importance to endeavours that really matter to wider society, focussing on inhabited worldviews, constitutive narratives and meanings that are used to structure life and work (Pattison, 2007: 285). As well as this embedded nature of individuals within time, place and person; life is about a journey of change and transformation or development. Practical theology has the ability to provide greater insight or an approach that can engender transformation or re-evaluation creatively and imaginatively through critical dialogue (Bennett et al, 2018:7-11). Utilising the findings and theory from the critical conversations and review of case studies, Table

4, shows a logic model that has been devised and can be implemented in local areas to help raise the awareness and increase health and religious literacy within professionals and the public. The logic model is theory driven (ideologies and case studies chapters) and displays inputs, activities, outputs and outcomes of the increasing health and religious literacy programme It demonstrates that it is only through action at multiple levels to improve the health and religious can the appreciation of worldviews and development of a common language of healing can commence between public health and Christian healing.

British theologian and bioethicist, Alastair Campbell defines the nature and scope of contemporary practical theology as requiring political awareness and theological courageousness in order to study and influence ecclesial and secular specific social structures and institutions. Such an approach will be through findings that will mostly be in terms of proposals that are transformative for restructuring individuals, communities and societies (Woodward & Pattison, 2000: 77). The enterprise of practical theology is to give regard to the initiatives in which the continuation of God's labour of renewal and restitution becomes apparent, within and outside the church i.e. nature of church's life open to the world through kerygma (gospel preaching - witness), koinonia (community – fellowship) and diakonia (helping the needy - service). The findings of practical theology in the form of propositions are in order to restructure, renew and reform the life, witness, fellowship and service for Christians, both within secular and religious social structures. These deliberated proposals are during the passage of time put under fresh scrutiny and fresh theological reflection, essential for practical theology, in order to ensure the contemporary relevance of faith, that is not just 'tips' or life but one with socio-cultural and political emphasis and relevance (Woodward & Pattison, 2000: 84-85).

Table 4 - Health and religious literacy logic model

Program: Developing collaborations and strengthening partnerships between preventative public health and Christian healing

Goal: Improve literacy of religious and secular worldviews on health and illness

Inputs	Activities	Outputs	Outcomes
Public health / clergy professionals	Provide education and training on the interaction of health and faith Promote a holistic view of health and illness	Incorporation of the role of religious / secular health models in training curricula Mapping / Audit of health provision within health and faith sector Public health promotion and clerical sermons that tackle current health issues	Increased literacy (knowledge, skills and confidence) on the religious and secular worldviews of health and illness i.e. common language Improved access to and uptake of services Identification of gaps in service provision Relevant and context specific social action to improve the health of communities and eschew mistrust Identification of challenges that can inform appropriate community and co-production approaches
Academics (theology & public health)	Interdisciplinary research to investigate health seeking behaviours (intersectionality)	Qualitative studies of role religious faith has on health in dominant secular society Support evaluation of current partnerships to enhance evidence base Systematic reviews highlighting best partnership practice through case studies	Improved evidence base to inform and influence policy formation Sharing best practice to inform suitable commissioning of community services
Politicians (local & national government)	Develop policy guidance on function of faith in public health and faith institutions	National and local strategies to guide religious and health partnerships Reduce “bureaucracy” to facilitate partnerships Highlight action guiding roles of religion and health in society	Incorporation of faith organisations around the table to discuss the formation of policies and programmes on health improvement Co-production of projects and neighbourhood renewal Faith organisations seen as essential spokes of the community / society and not just filling gaps of the state

Assumptions

Desire for dialogue and cooperation is mutual

Dialogue may challenge current status quo

Transformation of practice

External Factors

Cultural, economic, political, historical, social and health influences

Current spirit of the age – Austerity / social community practical theology

The critical conversation through a theologically reflective practical theology approach utilised within this thesis ensures that faith remains relevant to the opportunities and obstacles of collaborative health between public health and Christianity today. Rather than keeping these action guiding ideologies in separate boxes and opening either at the church or at the clinic, they can be seen as mirror images of each other, such that the weaknesses and strengths of each reinforce each other (Lambourne, 1995:113). The overarching factor that emanated from the ideological analysis (Chapter 3) and case studies within Chapter 4 was the limited dialogue between public health and Christian healing in contemporary times is due to the limited comprehension of each other's worldviews, lexicon and therapeutic worlds. Both theologians and public health specialists need to acquire skills in literacy of each other's worldview and how each "experiences" health and illness. They also need to concentrate on factors that promote healthy worlds within communities (assets-based approach) through a model developing a narrative around the principals that enhance life (Gunderson and Cochrane, 2012: 60), rather than pursuing the dominant deficit, disease model of health and wellbeing.

Assessment questions for collaborative dialogue

Following from the identification of opportunities and obstacles from the review and case studies, the following set of questions / prompts have been created to enable local public health and churches (religious organisations) to formulate and initiate collaborative dialogue.

- *Overall consideration*

1) As the collaboration of faith organisations and public health is an interaction of distinct disciplines, how do you prevent paradigm imperialism and ideological erosion?
2) How can you ensure one partner doesn't co-opt the other?

- *Local Authority considerations*

3) Is there any current dialogue between faith and health organisations?
4) If no, has an assessment of the obstacles preventing this dialogue been conducted? If yes, has any mapping been conducted to elucidate the type of partnerships? Is there a multi-faith forum? Was any broker organisation involved in facilitating this conversation? E.g. Public health England or Third sector organisation? Does public health consider religion as an essential social determinant of health?
5) Does the local authority have any arrangements as a whole to work with faith groups? E.g. Faith Covenant of All Party Parliamentary Group. Is there any senior leader in the local authority, public health and faith group interested in championing collaboration? Has the development of a robust evaluation process been designed to measure outcomes of any collaboration?

- *Local Church (denomination) or any faith organisation considerations*

6) Do faith groups understand the health needs of their congregations and local communities?
7) Have health and wellbeing approaches been piloted in faith settings? How can theology be transformative and mutative that makes a real difference to the lives of people?
8) Can a practical theological approach (theological reflection) to understanding health and illness facilitate how myths, symbols and metaphors of faith may impact their lives? How can a dynamic and imaginative theology of health be developed that allows creative and imaginative solutions to contemporary challenges? Is there any specific training required to facilitate dialogue?
9) Can theological activity revolve around a contemporary societal issue, giving it relevance e.g. mental health / loneliness? How can partnering with public health or other secular partners nurture human flourishing? Can other local governmental departments benefit from partnering and collaborating with faith organisations? E.g. housing, volunteering, employment.
10) Following steps 1 -9[6] a plan (based on PHE healthy mosques guide) can then be created for dialogue under the following headings:
    a. Leadership and vision
    b. Planning & Partnerships
    c. Training
    d. Communication
    e. Evaluation

[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/619891/Guide_to_Healthy_Living_Mosques.PDF - Accessed 2nd September 2019

Limitations

A major limitation of the dialogical interrogative methodology of theological reflection utilised in this study is the tendency for it to lead to further questions, rather than provide eternally valid solutions. It has also been criticised as a method that lacks depth. Both these critiques are true to an extent, however, the initiation of a theological reflective conversation between interdisciplinary partners can be an effective the mechanism through which current challenges can be tackled through collaborative interdisciplinary dialogue (Pattison, 2007: 12). It could be argued that the critical dialogue methodology is not an insufficient model of reflecting theologically, as theology is about providing eternally valid answers rather than leading to further questions through an interrogative conversational method. In response to this, it can be said that rather than glossy unrealistic answers to complex contemporary issues, this conversational approach allows exploratory theological enquiry. It is also contextual and allows assessment and appraisal of existential issues of faith and practice, providing the construction of more a critiqued world view. It has also been pointed out that a critical conversational approach may produce artificial and subjective analysis, which is a possibility as it will only deal with some aspects of situations rather than being comprehensive. It must be acknowledged that theological reflection will often be of limited validity and idiosyncratic, highlighting that theologies can be disposable and contextual (Pattison, 2000: 142-143).

Another key constraint within this study was that the theological responses to depression and AIDs did not analyse and disaggregate them by different churches, Anglican / Eastern Orthodox or by internally pluriform denominations. The plurality of belief and practice result in a complex array of responses both on a macro level (faith institution) and also on a micro level dependent on an individual's degree of

knowledge and adherence to their faith. Although different perspectives and interpretation of the Bible to health and healing exist within different denominations, they manifest within the context of the church and a loving God.

The major focus of my selective intellectual review has been within the UK and the interaction of health, illness and healing with Christianity. The risk of these narrow limits to my review may have curtailed a wide-ranging cultural, social and intellectual analysis of the interaction of faith groups and health care providers. As a result, the opportunities and obstacles identified that may help or hinder collaborative healing need to be contextualised to present day world experiences and may not be universally applicable given the ambivalence and variability of reality and experiences of individuals and communities. The critical conversation was conducted through several intellectual engagements across several disciplines (historical, social) to dissipate the danger of reductionism. Although the critical conversation and historical intellectual review provided a historical dialectical understanding of the collaborative healing in relation to AIDs and depression highlighting the ideological continuities and discontinuities (paradigms), both Christian theology of healing and public health must tackle timely, appropriate and existential challenges.

In terms of the dialogue between preventative public health and Christianity on a local level, it is necessary to be cognisant of the pluralist nature of these two worldviews. There are at least three dangers in dialogue between societies of knowledge (Lambourne, 1995: 115):

i) Those engaged in dialogue may only represent a small minority within the pluralist society within which their profession exists

ii) The integration with another discipline may draw representatives from their own profession to exclude them due to the dialogue may seem to contravene purist ideologies

iii) The dialogue may without realisation become a monologue, as the weaker (ideologically, zeitgeist) partner only contributes ideas that are congenial to the stronger partner without challenge or critique

Nearly all the current dialogue between public health (speciality of medicine) and Christianity (healing ministry) has been between a subsection e.g. such as that proposed here; public health and Christian Ministry of healing. As a consequence there cannot be one dialogue but many dialogues that are required due to the multiple systems of knowledge that are present (pluralism) within disciplines. Many of those involved in the dialogue between public health and Christianity have been blinded from envisaging the process as a meeting between two ways of 'experiencing as' the world (Lambourne, 1995:122). Any dialogue of public health and Christianity that is being investigated in contemporary times is being conducted in an age of secularisation, where there is scant authoritative emphasis on the sacred cosmos to form and shape social identities. However, many of the metaphors, such as causality, blame, hope and meaning used by public health professionals, clergy and patients to understand illness are questions with religious connotations (Everitt, 1987).

Although asset-based approaches to health improvement depart from the community deficiency model, Friedli (2012) alludes that this approach may be advancing neo-liberal market ideology and allowing the government to preserve a dysfunctional system that public health and faith groups are supplementing unintentionally and potentially widening health inequalities.

Community Model of Collaborative healing

A further key finding from the critical conversation and review of opportunities and obstacles for collaborative healing has been the importance and role of a community model or approach to health and wellbeing. The term community may be applied to indicate associations, interactions and identities of people that often share common affinities of place, experiences or worldviews (NICE, 2016: 11). Communities are rarely static but rather lively, organic and multifaceted social settings, where identities and commitments wax and wane due to evolving social norms within varying contexts. Communities are part of the social, political, economic and health systems in which individuals reside and can influence the contemporary social or health systems through active participation. Such participation (civil society) or "whole of society" or "whole systems" approach has known to empower individuals and communities, combat social exclusion and mobilise community resources. Although many central government changes have advocated a greater involvement of individuals in localised public service delivery through faith and community groups, the challenge in translation has been the domination of these community centred approaches to be professionally led, resulting in a lack of ownership by individual community members (South et al, 2013).

The reassignment of public health functions from the NHS to local government in 2013 as a result of the Health and Social Care Act 2012 created opportunities for improving population health in local areas health through individual, community and whole system approaches. Place and ideology based worldviews can make a critical contribution to the health and wellbeing of community life through the mobilisation of community assets and promoting equity. The National Institute for Health and Care

Excellence (NICE) endorses community based approaches for improving population health and tackling inequalities in health (NICE, 2016).

A recent report (Faith Action, 2017) that investigated the key ingredients for building and sustaining effective community initiatives revolved around the sense of belonging. Other core elements that emerged from many of the community groups that were interviewed where; the importance of humour, a sense of empowerment, longevity (which bred trust), dedication (going the extra mile) and hospitality. The centralised tenet of belonging within these faith and secular based community hubs, often galvanised around tackling a social issue (tackling isolation) mutually supported individuals to transfer from a feeling of vulnerability to a sense of confidence and strength. These community hubs empowered individuals to obtain early support through crucial interventions that reduced the escalation of issues to a crisis point (Faith Action, 2017: 43).

A diverse range of community centred approaches and interventions are known that can be utilised to ameliorate poor health and address the wider and social determinants of health. These approaches are based on the core concepts of equity and social connectedness that draw on community assets to strengthen communities in relation to the social context (South et al, 2019).The community centred approaches describes four main groups methodologies for improving health and wellbeing in communities; i) strengthening communities, ii) volunteer and peer roles, iii) collaborations and partnerships and iv) access to community resources. In terms of applying these approaches to the dialogue of collaborative healing between public health and Christianity, the collaboration and partnership approach seems the most relevant, as it involves professional / public bodies to work in partnership with communities through community based participatory research (CBPR)

methodologies as they necessitate the requirement for dialogue. The collaboration and partnership community approaches also develop programmes that are area-based initiatives (ABI) and work through community engagement and co-production. Such collaborative community approaches compel the development of community leadership capability and capacity building that aims to mature equitable needs orientated services (South et al, 2019). Communities are the vital building blocks for health and wellbeing in localised areas with the developing of localised collaborations and partnerships between civil, civic and community organisations a key priority to reduce health, social and economic inequities (NICE, 2016: 7-11).

Building healthy worlds and healthy communities is not simply the implementation a bundle of healthy policies within an area. It requires the cooperation and transition of behaviour within linked community systems to instigate social change by realigning them around common values (Gunderson, 2000). Durie and Wyatt (2013) report on a connecting communities (C2) transformational learning programme informed by complexity theory. Complexity theory provides a set of standards that views communities as open and dynamic rather than closed systems where the behaviour of the components responding to change is not linearly proportional to any intervention but rather dependent on the relations and levels of the system (Rutter, 2017).

In terms of practical theology, many Christian denominations in recent times are attempting to erase the artificial boundaries that exist in individuals and communities between work and worship in order to integrate thought and practice. With a strong sociological emphasis and corporate approach, the rediscovery of this Christian fellowship or common life revolves around the necessity of a community mindset to identify individual and communal issues and how the Church as a crucial tenet of the

community can improve the life in all its dimensions (Lambourne, 1966: 113). This fellowship that embraces the suffering of its members and neighbourhood becomes a therapeutic community or therapeutic landscape, where the community in itself is the “best medicine”. Recent healthcare policy debate on community health that revolves around the partnering of the Church and public health has rejuvenated attention to the benefits and barriers of this collaboration (Brooks and Koenig, 2002). Due to the current limited engagement, there is a need for coordination between the Church and public health. Many third sector organisations within communities are functioning as “broker organisations” as they are able to connect the health assets and translate the collaboration between public health and the Church (Demos, 2019). The emerging narrative is the need to deal with individuals but also utilise the community (assets-based health) to discover and utilise their own strengths towards salvation and salutogenesis (Lambourne, 1995:109). In order for this conceptual integration between these worldviews, interaction and dialogue is required at different levels. This entails examining the determinants (genetics, family, social networks, economics, politics) of health (Barton and Grant, 2006), and the construction of health (religious and secular ideologies) individuals and communities have with the world, i.e. their healthworld (Germond and Cochrane, 2010). This type of interaction between individuals and their healers (religious or secular) requires communicative action not stipulated on adherence or compliance but concordance. Concordance requires the public’s interaction regarding healing with the clergy or clinicians to inculcate an atmosphere that can allow the discussion of concerns, without the impediment of power relations (Stevenson et al, 2004). The integration of religious and secular health systems may seem as theoretically incoherent, however, individuals that reside within this hybrid reality are able to navigate their healthworlds through communicative and coordinated action subject to cultural and linguistic

constructions (Germond and Cochrane, 2010). The concept of a healthworld, building on lifeworld of (Habermas, 1987) provides a means to understand pluralistic mixing of strategies that individuals may utilise to interpret health and wellbeing. The healthworld lens transforms alternative understandings of healing into opportunities for socially and culturally relevant healthcare provision. This nuanced understanding of healing will allow the multiple worldviews to speak a common language to ensue in collaborative dialogue. In order for prevention and prayer to make a difference, it is necessary to ensure dialogue is contextual and community orientated, considering the whole person through pluralistic perspectives as oppose to a monolithic worldview. There is no universal public health or universal theology, as they have to be discovered in each generation and community, which leads to contextual ethics for a particular time and place.

CONCLUSION

Within the UK, as the process of secularisation progresses, paradoxically religion also endures it presence in the public secular sphere. As a result, the religious narrative cannot be understood without the secular narrative due to their social, historic and political intersection. Even though there is a decline in practice, vicarious Christianity is still dominant. Collaborative healing between non-religious (secular) and religious action guiding worldviews has throughout history been involved in providing relief from illness and disease. The multidimensional constructs of lifeworlds and healthworlds of individuals and communities have resulted in pluralistic health seeking and healing strategies in different epochs. However, many faith based providers have developed strategies to enable to vary the degree of intersection faith has on their day to day practice and ranges from faith saturated to faith partnership collaborations.

Whilst research suggests that faith-based organisations are effective and experienced provider of preventative public health care services, they have had to transform and be transformed through interdisciplinary practical theological conversations. This study was able to elucidate the opportunities and obstacles of collaborative healing between Christian healing and preventative public health within contemporary UK society by inhabiting a practical theological framework. The illumination of insights emanated from the historical reviews of the interaction of AIDs and depression (case studies) with Christianity, whilst the critical conversation captured dialectically the experience of these social, political and theological interactions. The findings were also able to propose conceptual factors that need to be considered when examining collaborative healing in today's postmodern and complex world of religious and secular healing. The major opportunities for

collaborative healing was the ability to develop community healing and create therapeutic healing landscapes and empower people through health and religious literacy to reduce the stigma of ill health. In terms of obstacles, the lack of communication between secular and religious healers and the complex realities of individuals and communities caused the development of separate healthworlds. The lack of dialogue between these worldviews exacerbated certain prejudices and stigma towards ill health.

As an interdisciplinary study, the alignment between public health's tripartite; place, person and time with practical theology's tripartite of faith, practice and reality provided a mutual framework to conduct this research. The findings were able to generate a practical programme of improving health and religious literacy within the church, academia and policy, as well as the development of a self-assessment to inculcate mutual dialogue between local public health and faith organisations.

A decisive understanding from this study is that there can be no timeless or context free Christian theology or public health, although their realities are informed by the past, present and future. These action guiding worldviews need to be analysed as integrated building blocks of the societal milieu and not detached islands that evolve and are transformed by political and social shifts. The ability of mutual and critical dialogue enables each worldview to interpret its reality within individuals and communities, as oppose to malign each other and bring reason or revelation to the fore. The consideration of religion as a vital social and structural determinant of health and wellbeing is crucial in postmodern society due to its interconnectedness to other determinants of health in complex ways.

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